# Participant Referral Form

**Preferred language for future correspondence;**

**English** ☐ **Welsh** ☐

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|---|---|
| Client's Name: | D.O.B: |
| Address;<br><br>Telephone No. | |
| Referrer's Name:<br><br>Referral Agency:<br><br>Telephone No./ E-mail: | |
| National Insurance no: | |
| G.P Name:<br><br>Contact No.<br><br>Medical History:<br><br>Current Medication:<br><br>Any Side Effects That Would /Could Limit Work Placement: | Surgery details: |

*What benefits are the participants receiving? (Please tick all that apply)

Jobs Seekers Allowance: ☐ Start Date ________________

Incapacity Benefit: ☐

Employment Support Allowance: Work ☐ Support ☐ Start Date ________________

Disability Living Allowance: ☐ Level __________________

Income Support ☐

Other ☐ Please specify:__________________________________

| Brief details of Substance Misuse history: |
|---|
| Does the participant have any additional support needs which we should know about?<br>Please describe: |
| When would you like to arrange a meeting and do you have any preferences about location? |
| Please give details of participant's interests and preferences for future development (i.e. Basic skills, soft skills, I.T teaching, job search/other), |
| *Please attach any relevant information including a Risk Assessment which will help us assess the needs of the Participant.*<br><br>To your knowledge has there been: (since last risk assessment)<br><br>Any suicidal ideation or action, or episodes of self harm?<br>If Yes, detail:<br><br>Any threats of or acts of violence to others (abusive behaviour)?<br>If Yes, detail:<br><br>Any gender or ethnic issues?<br>If Yes, detail:<br><br>Change in child care status?<br>If Yes, detail:<br><br>Any deterioration in self-care?<br>If Yes,detail: |
| Next of kin details:<br>Name:<br><br>Address:<br><br>Telephone No: |

| Referrer's Name: |
|---|
| Referrer's signature: |
| Participants signature:<br><br>I can confirm that I give permission for this information to be shared with the Coastal Team: |
| Date: |
| Thank you for completing this form and for your referral. We will contact you on receipt of this form to arrange for an appointment. |
| Please note that these questions are designed to ensure that we have the information we need to ensure your client has a positive experience. However, if our project is not suitable for your referral, we will aim to help find alternative provision which better meets their needs.<br><br>**Please return to: Coastal, Prism, 43 Merlins Hill, Haverfordwest, Pembs, SA61 1PE**<br><br>For office use only.<br><br>COASTAL ID No.<br><br>Support Worker:<br><br>First Meeting : |

Fax : 01437 776742

**Please return to: Prism Coastal, 43 Merlins Hill, Haverfordwest, Pembs, SA61 1PE**

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