REFERRAL FORM

SKILLS TRAINING ASSESSMENT RESOURCE SERVICES

Please enter all information and continue on separate sheets if necessary.

INDIVIDUALS DETAILS

Title (Mr/Mrs/ Miss/Ms)		
First Name(s)		
Surname		
Address		
Postcode		
Telephone	Mobile:	Home:
Date of Birth		
	Emergency Details	
Name of next of Kin or nearest relative		
Address of Next of Kin or nearest relative		Postcode:
Telephone of Next of Kin or nearest relative	Mobile:	Home:

REFERRAL AGENT (e.g. G.P; Social Worker, Family member; Self-referral)

Name		
Name of Agency		
Address		
		Postcode:
Telephone	Mobile:	Other:
Email		
Type of Referral (e.g. Family member)		

GIVE DETAILS OF ANY HEALTH CONDITIONS, MEDICATION OR ADDITIONAL NEEDS

ALLERGIES:

HAVE YOU ANY RISK ASSESMENTS IN PLACE

YES **NO**

PLEASE INDICATE THE LEVEL OF SUPPORT NEEDED

Give details of any support in the corresponding column

Level of Support Given	Details of Support Given
High level of support	
Moderate level of support	
Low level of support	

PLEASE GIVE DETAILS HOBBIES/INTERESTS

PLEASE OUTLINE ABILITY TO COMMUNICATE VERBALLY OR WRITTEN EFFECTIVELY AND LEVEL OF UNDERSTANDING

Effective communication skills, requires minimal support	
Reasonably effective communication skills, requires some support	
Is unable to communicate effectively, requires a lot of support	

PLEASE OUTLINE REASONS FOR REQUESTING A PLACE AT THE SKILLS CENTRE

NO REFERRAL SHOULD BE MADE WITHOUT PRIOR CLIENT/FAMILY / AGENCY CONSULTATION. HAVE YOU MADE THE CLIENT/FAMILY/AGENCY AWARE OF THIS REFERRAL?

Please indicate with an 'X'

Yes	
No	

Name of Referring Agent:

Signature of Referring Agent: Date:

Approved referral

Please return to Lisa Sage, STARS Community Creations Centre, 10 Garth Drive, Brackla Industrial Estate, Bridgend, CF31 2AQ, Tel 01656 333023 ext 3

charity@starscare.co.uk