*Providing Opportunities & Activities for adults with mental health issues or learning disabilities*

**Homewood Road, St. Albans, Herts AL1 4BH Tel: 07399 570675**

**Email: flaviascipioni@stalbansmencap.org.uk**

**Team Leader: Flavia Scipioni**

**Referral Form**

|  |
| --- |
| We offer a Day Centre, activities, trips and workshops to adults (18+) with learning disabilities or those experiencing mental health issues. Our services are delivered from our centre in St Albans. Anyone wanting to access any of our services will need to complete this referral form. They will then be invited to attend an induction where further detailed information will be taken to help us get to know them. All information will be kept on file and is confidential. Please note that we do not administer medication or do personal care. Anyone needing this level of care will have to attend with their own carer.  |
| Service User Full Name: | Date of birth |
| Diagnosis: | Service User Phone number |
| Service User Address | Service User Email |
| GP: name, address, telephone | Emergency Contact:Name:Phone:Email: |
| Key worker and/or care coordinator detailsName:Phone number:Email Address: | Name & contact details of person making referral (if not a self-referral) |
| Here is a list of the main services we provide. Please tick which services you are interested. in:**Activities** **2pm – 3.30pm**Art class Day Trips  Music sessions Exercise sessions  Other (Please state)Reading Group **Life Skills** Mental Wellbeing Cookery Other life skills (Please state)**Day Centre** **9:30am – 2pm**Monday Tuesday  Wednesday Thursday   **Along with our regular activities we deliver one off or various short courses, activities and events.**  |
| At the **Day Centre** members (service users) bring their own packed lunch. Sometimes, we hold special events where food is provided, all information would be sent via email or letter. Please let us know below if you have any allergies/ intolerances.  |
| Dietary needs – e.g. Diabetic/vegetarian/cultural/preferences/Allergies  |
| Reason for referral? (why would you like to attend Trinity Community Project) |
| **For support staff only – Please provide us with a recent, relevant risk assessment which includes medication/safety in community/behaviour management/choking risk/falls risk etc. PLEASE KEEP US INFORMED OF ANY CHANGES**  |
| Helpful information to support you: (e.g. mobility, community access / safety, preferences, communication, dietary, memory, behavioural, mental health etc).Any other relevant information: |
| I give permission for the Trinity Community Project to obtain information (including risk assessments and care plans) from other agencies which are supporting me. I understand that my details will be kept confidential and held on Trinity Community Projects’ electronic database. This information is collected for person centred care. I know I can request to have my information removed from TCP database. I understand I can request a copy of TCPs data protection policy. I understand that TCP can contact me/relevant bodies if they are concerned about my wellbeing.  Please tick here if you understand and agree to this disclosure**Service User signature Date:** |
| **Completed by** (if different from above)**Name:****Email:****Phone:** | The details given are accurate and to the best of my knowledge.**Sign: Date:** |
| **We will automatically put you on our mailing list to enable you to stay updated on our services as they change regularly.****If you do not want to be put on the mailing list please tick the box opposite** |  Please do NOT include me on the mailing list: |
| **How did you hear about Trinity Community Project?** |