ST. DAVID'S BRADBURY DAY CENTRE
REFERRAL FORM

To be filled in by the referrer e.g. Health Visitor, Social Worker, GP, Neighbour, Relative with permission of the person being referred.

REFERRED PERSON

Name: ……Date of Birth : ……..

Address: …….
…….

……

Telephone Number: … …… Age on Referral: …….

Carer …….. Relationship: ……

Emergency Contact Number: …….. Living Situation: ……

……

NEXT OF KIN

Name
…….

Address … …… …….

…… ……

Telephone Number……

OTHER CONTACT NAME (e.g. neighbour/friend)

Name ……
……

Address ……
…….

Telephone Number ……

REFERRER:

Name …… …….

Address … ……..

…… …….

……

Telephone Number … …… Date of Referral
……..

REASON FOR REFERAL
……. …….
……

IF THE PERSON WHO IS BEING REFERRED IS HOUSEBOUND, PLEASE STATE, ALSO STATE REASON
No
… ....
……

……

……

DOES THIS PERSON ATTEND ANY OTHER CLUBS OR DAY CENTRES **YES/NO**

IF YES WHICH ONE(S
……

……

The person being referred will be visited by an appropriate member of staff from the Centre, to assess suitability.

If the referrer, relative or friend would like to be present at the assessment, please state.

…… …… ……

Doctors Name & Address;
……

Please return to:

Maureen Moore
Manager
St. David's Bradbury Day Centre
57 St. David's
Newtongrange
Midlothian
EH22 4LF

Telephone Number 0131 660 1285
Email:- info@stdavidsbradburydaycentre.org.uk

www.stdavidsbradburydaycentre.org.uk

ST. DAVID'S BRADBURY DAY CENTRE
REFERRAL ASSESSMENT FORM

General Health:

Mobility:
Hearing:
Sight:
Continence:
Special Dietary Requirements:
Allergies:
Appetite/Weight:
Sleep Pattern:
Other Illness or Disabilities:
Speech Difficulties:

Medication:

Mental Health:

Orientation of time, place, person & things:
Memory – short/long term:
Concentration:
Motivation:
Mood:
Behaviour:
Communication:
Expressing:
Understanding:
Wandering:
Restlessness:

Personal Skills:

Personality:
Sociability:
Domestic Care:
Personal Care:
Social Habits:

Carers:

Health:
Emotional Support:
Carers Group:
Carers Support Worker:

Past History:

Social Contacts:
Previous occupation:
Family:
Other services involved:
Religion:
Interests:
Activities:
Pets:

Transport:

Can the person walk unaided to a car?	Yes/No
Can the person get into the back seat of a car?	Yes/No
Is a tail-lift ambulance required?	Yes/No
Has the person a mobility aid?	Yes/No
(if yes what type)	

At the Centre

Assistance with toileting	Yes/ No
Management for continence	Yes/No
Assistance with walking inside?	Yes/No.
Assistance with eating/drinking?	Yes/No
Assistance with clothing?	Yes/No

Assessor

Is the person suitable for the Centre

If no, brief explanation why

Information given to referrer	Date:	By:
Place Offered	Date:	By:

Would it be desirable to have a member of staff visit prior to attendance:

Visit Arranged	Date:	By:
Place Accepted		

If yes, transport arrangements organised by:

Start Date: