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| **OFFICE USE ONLY** | |
| Identification Number |  |
| Date received |  |
| Date to be contacted by  (2 Week Point) |  |



PLEASE RETURN TO:

Sheriff Court Building

Dunnotar Avenue

AB39 2JD

or

eMAIL: info@pillarkincardine.org

**PROFESSIONAL REFERRAL FORM**

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| --- | --- |
| **CLIENT DETAILS** | |
| NAME: Click or tap here to enter text. | DATE OF BIRTH: Click or tap to enter a date. |
| ADDRESS: Click or tap here to enter text. | HOME TELEPHONE: Click or tap here to enter |
| MOBILE: Click or tap here to enter text. |
| POSTCODE: Click or tap here to enter text. | EMAIL ADDRESS:  Click or tap here to enter text. |

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| --- | --- |
| **REFERRER DETAILS** | |
| NAME: Click or tap here to enter text. | AGENCY: Click or tap to enter a date. |
| ADDRESS: Click or tap here to enter text. | HOME TELEPHONE: Click or tap here to enter |
| MOBILE: Click or tap here to enter text. |
| JOB TITLE: Click or tap here to enter text. | EMAIL ADDRESS: Click or tap here to enter text. |

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| **DIAGNOSIS (please give details e.g. hospital admissions, prescribed medication etc....)** |
| Click or tap here to enter text. |

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| **CRIMINAL CONVICTIONS (Does the referred client have any criminal convictions spent or pending?)** | | | |
| **NO** | ☐ | **YES** | **☐** |
| **IF YES PLEASE SPECIFY** Click or tap here to enter text. | | | |

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| **REASON FOR REFERRAL? (what does the client hope to achieve by attending Pillar) please tick ALL appropriate indicators** | | | | | |
| Build Confidence | ☐ | Reduce Isolation | ☐ | Build Social Skills | ☐ |
| Build Self Esteem | ☐ | Add Structure to Week | ☐ | Develop Better Coping Strategies | ☐ |
| Become Work Ready | ☐ | Peer Support | ☐ | Improve Self Management Skills | ☐ |
| Other (Please specify) | Click or tap here to enter text. | | | | |

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| **DETAILS OF GP & OTHER AGENCIES CURRENTLY PROVIDING SUPPORT** | | |
| **Surgery Name And Address** | **Name Of Client’s Regular GP** | **Telephone** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Agency Name And Address** | **Contact Name** | **Telephone** |
| Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text. | Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text. | Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text. |

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| **ADDITIONAL INFORMATION (Please include any other relevant information)** |
| Click or tap here to enter text. |

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| **PLEASE CONFIRM THAT THE REFERRAL HAS BEEN MADE WITH THE CLIENT’S CONSENT** | | | |
| **SIGNATURE OF REFERRER** | Click or tap here to enter text. | **DATE** | Click or tap here to enter text. |

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| **OFFICE USE ONLY** | | | |
| **INITIAL CONTACT MADE (DATE)** | Click or tap here to enter text. | **ACTION REQUIRED** | |
| **REFERRAL APPOINTMENT**  **ARRANGED FOR (DATE)** | Click or tap here to enter text. | **BECOME MEMBER** | ☐ |
| **SERVICE USER ONLY** | ☐ |
| **ACTIONED BY (STAFF NAME):** | Click or tap here to enter text. | **Information ONLY** | ☐ |
| **STAFF SIGNATURE:** | Click or tap here to enter text. | **NO FURTHER ACTION** | ☐ |
| **DATE:** | Click or tap here to enter text. | **SIGNPOSTED TO: (Give details)** | ☐ |