



**BEITEL CARE SERVICES LIMITED**  
**Head Office-1 Woodham Road London SE6 2SB**  
**Tel: 02039768152/07427051957**  
**email: [fordel@beitelcareserviceslimited.co.uk](mailto:fordel@beitelcareserviceslimited.co.uk)**

## CLIENT DETAILS

*Please complete referral form as fully and clearly as possible*

<b>Name:</b>	<b>Current Address:</b>
<b>Date of Birth:</b>	<b>Ethnicity:</b>
<b>Religion:</b>	<b>Gender:</b>
<b>Marital Status:</b>	<b>Contact Number:</b>
<b>FAMILY CONTACT</b>	
<b>Next of Kin/Guardian:</b>	<b>Current Address:</b>
<b>Contact Number:</b>	<b>Relationship to Applicant:</b>

**REFERRAR DETAILS****Referrer Name:** \_\_\_\_\_**Tel No - Landline:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_**Address:** \_\_\_\_\_**FUNDING AUTHORITY****Contact Name:** \_\_\_\_\_ **PCT:** \_\_\_\_\_**Tel No:** \_\_\_\_\_ **Fax:** \_\_\_\_\_**Address:** \_\_\_\_\_

\_\_\_\_\_

<i>Please indicate if the applicant is currently involved with any of the following</i>	<i>Yes</i>	<i>No</i>	<i>Contact Details</i>
GP:			
Psychiatrist/ Ward Consultant/ RC:			
CPN/ Social worker:			
Advocate:			
Probation Officer:			
Other:			

**CURRENT DIAGNOSIS**

Diagnosis:

Section:

Last Hospital Admission:

Brief outline of mental health history:	Brief outline of current mental health needs:
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Psychological Treatment:	MOJ Restrictions:
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Please state if there is any side effects from the client's medication:	Please state if there are any triggering contributions:
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**MEDICAL CONDITION**

*Please indicate if the applicant has any physical or medical concerns*

Current medication

Any issues with compliance

Any issues around engagement with services

Mobility

Learning Disability

Communication

Any other medical conditions

**RISK ASSESSMENT**

<i>Please indicate if the applicant has exhibited any of the following</i>	<i>Yes</i>	<i>No</i>	<i>Details of events</i>
Self Harm:			
Self neglect:			
Physical Aggression:			
Verbal Aggression:			

Substance Abuse:			
Exploitation:			
Inappropriate sexual Behaviour:			
Absconding:			
Financial Abuse:			
Arson:			
Threatening behaviour:			
Criminal Convictions:			

**CLIENT INCOME**

<i>Please indicate if the applicant is in receipt of any of the following benefit</i>	<i>Yes</i>	<i>No</i>	<i>Details of Amount</i>
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National Insurance Number:

DLA/ AA:

Housing:

Pension:

Employment and Support

Incapacity			
Income Support			
<b>DAY TIME ACTIVITIES</b>			
<i>Please indicate if the client is involved in any of the following:</i>	<i>Yes</i>	<i>No</i>	<i>Details</i>
Employment			
Day Centre			
College			
Training Programme			
Substance Interventions			
Psychological Interventions			
Recreational Activities			

**DECLARATION: (the client and the referring agency should sign this declaration)**

The information I have given is true and complete. I understand that Beitel Homes may withdraw support if I deliberately give false or misleading information. I authorise enquires to be made and information obtained if they are necessary to my application.

Signature (client).....Date.....

Name of person completing application.....

Signature (Agency).....Date.....

Job Title.....

Please indicate which documents are enclosed with the referral:

CPA	<input type="checkbox"/>
Risk Assessment	<input type="checkbox"/>
ADL Assessment	<input type="checkbox"/>
Probation Report	<input type="checkbox"/>
Discharge summary	<input type="checkbox"/>
Social Circumstance Report	<input type="checkbox"/>
Psychiatric Report	<input type="checkbox"/>

**PLEASE SEND COMPLETED REFERRAL**

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**YOU CAN ALSO SEND THIS FORM ELECTRONICALLY TO:**

**[fordel@beitelcareserviceslimited.co.uk](mailto:fordel@beitelcareserviceslimited.co.uk)**

*Beitel Care Services limited.*