



Alan Shearer Short Break Centre Referral Form

The word “client” is used throughout this form when referring to the person using the Alan Shearer Short Break Centre.

PERSONAL DETAILS

Name of Client

Date of Birth Sex

Religion Weight.....

Name of Parent / Guardian (*if applicable*)

Home Address

..... Post Code

Telephone No Mobile No

Email

Diagnosis of Condition

Allergies (*if any*)

.....

Please provide an emergency contact. This should be a close relative or friend who can be contacted if the above telephone numbers are not available at the time of an emergency.

Name

Address

..... Post Code

Telephone No Relationship

Name of Referrer

Address

Telephone Number Mobile No.....

Relationship to client

.....

PROFESSIONAL CONTACTS

Name of GP

Address

.....

..... Post Code.....

Telephone No

Hospital Doctor (*if applicable*)

Hospital Address

.....

..... Post Code

Social Worker (*if applicable*)

Address

..... Post Code

Telephone No E mail.....

Name and telephone of other Professionals involved e.g. Community Nurse, Physiotherapist,
school, college, day service etc.

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USING THE SERVICE

When would you / your client prefer to use the Alan Shearer Short Break Centre? *(Please tick)*

Weekdays Weekends No preference

How frequently would you / your client wish to access the service?

.....

How many consecutive nights would you / your client wish to access the service?

.....

FAMILY

Have you / has your client got any brothers or sisters?

Name: Age

..... Age

..... Age

..... Age

..... Age

Do you / does your client have regular contact with any other friends / relatives? *(Please list)*

.....

Does anyone else live in the family home?

Yes *(If yes, please list below)* No

.....

Do you / does your client have any pets?

Yes *(If yes, please list below)* No

Name: Type of animal

Name: Type of animal

Have you / has your client spent time away from home before?

Yes *(If yes, for how long?)* No

.....

Was it seen as an enjoyable experience?

Yes

No

Did any problems occur?

Yes (If yes, please list below)

No

.....
.....

Is there anything specific that might worry, confuse or make you / your client anxious or angry?

.....
.....

Do you / does your client have any specific interests? (Please list below)

.....
.....
.....

COMMUNICATION

Do you / does your client communicate verbally?

Yes

No (If no, please describe method of communication)

.....
.....

Please give the fullest detail of signs, gestures, makaton used.

.....
.....
.....
.....

Do you / does your client understand what is being said?

Yes

No

Do you / does your client understand short requests?

Yes

No

Are you / is your client able to understand tone of voice?

Yes

No

Do you / does your client have a speech impediment?

Yes

No

If **YES** please give details

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.....
.....

Do you / does your client have any hearing difficulties? Yes No

If **YES** please give details of any aids used

.....
.....

Are there any risks associated with communication? Yes No

If **YES** please give details

.....
.....
.....

EATING

Can you / can your client feed themselves? Yes No

If **NO** please detail assistance required

.....

What do you / does your client eat with? *Eg. Knife and fork, fork only, spoon, fingers*

.....

Do you / does your client require special preparation of food? Yes No

If **YES** please give details

.....
.....

Do you / does your client require special equipment? Yes No
Eg. Plate guard, slip mat, special cup etc

If **YES** please give details

.....

Please list your / your client's food / drink likes and dislikes

.....
.....

Do you / does your client require any special diet? *Eg. Diabetic, gluten free, low calorie*

.....

Do you / does your client have any cultural needs with regard to food / drink? Yes No

If **YES** please give details

.....

Are you / is your client allergic to any particular type of food / drink? Yes No

If **YES** please give details

.....

Do you / does your client have any food preferences? Yes No
Eg. Will not sleep without snack before bed

If **YES** please give details

.....

What is your / their time of last drink before bed?

.....

Do you / does your client have any difficulties in swallowing? Yes No

.....

Are there any risks associated with feeding? Yes No

If **YES** please give details

.....

.....

TOILETING – DAYTIME

Can you / your client use the toilet unaided? Yes No

If **NO** please state assistance required

.....

If **YES** do you / does your client use any signs or gestures to indicate a need to use the toilet?

.....

Do you / does your client require prompting to use the toilet? Yes No

If **YES** please detail any specific ways of prompting

.....

.....

Do you / does your client have any continence difficulties? Yes No

If **YES** please state approximately how often

.....

Do you / does your client wear incontinence pads? Yes No

Are there any risks associated with toileting?

.....

TOILETING – NIGHT TIME

Do you / does your client get up to use the toilet at night? Yes No

Do you / does your client require lifting? Yes No

Are you / your client ever incontinent at night? Yes No

If **YES** please state approximately how often

.....

Do you / does your client wear incontinence pads at night? Yes No

Please detail any other information we need to know about you / your client's toileting needs

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Are there any risks associated with toileting? Yes No

.....

.....

SLEEPING

Please describe a typical bedtime routine

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.....
.....

Describe the position you / your client sleeps in

.....
.....

Describe the type of bed you / your client sleeps in *Eg. Single, rail*

.....
.....

Describe the type of bedding you / your client prefers *Eg. Cotton sheets, blankets, duvet*

.....
.....

How many pillows and what types do you / does your client usually sleep with?

.....

What time do you / does your client usually go to bed?

.....

Do you / does your client usually:

- | | | |
|------------------------------|------------------------------|-----------------------------|
| Sleep alone | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Sleep well at night | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Require attention at night | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Experience dreams/nightmares | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Please list any other information about your / your client's sleeping habits that we should know

.....
.....
.....
.....

Are there any risks associated with night time / sleeping?

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.....
.....

PERSONAL HYGIENE

Can you / your client manage to wash without assistance? Yes No

If **NO** please describe what assistance is required

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.....

Can you / your client manage to bathe alone? Yes No

If **NO** please describe what assistance is required

.....
.....

Do they prefer a bath or shower? Shower Bath

How often and when do you / they like a bath or shower?

.....
.....

Do you / does your client use any bath/shower aids? Yes No

If **YES** please describe

.....
.....

Do you / does your client prefer any specific brand of soap, bubble bath, shower gel?

.....
.....

Is there anything about bathing / showering that causes you / your client distress, such as allergies to soap?

.....
.....

Please list any creams or lotions that you / your client use after bathing/showering?

.....
.....

Do you / does your client clean your or their own teeth? Yes No

If **NO** please describe how you assist

.....
.....

Do you / does your client shave? Yes No

If **YES** what method is used?

.....
.....

How often do you / does your client shave?

.....

Do you / does your client manage to shave yourself / themselves? Yes No

If **NO** describe assistance required

.....

If you / your client is female:

Do you / your client menstruate? Yes No

If **YES** what sanitary protection is used?

.....

Are you / is your client able to manage independently? Yes No

If **NO** describe the assistance she requires

.....

Are there any problems associated with menstruation? Yes No
E.g. Lethargic, pain, distress

If **YES** explain how this is managed

.....
.....

What medication do you / does your client take for pain relief for menstruation? *(If any)*

.....

Any risks associated with personal care tasks?

.....

DRESSING

Can you / your client dress and undress independently? Yes No

If **NO** please describe assistance required

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.....

Do you / does your client rely on verbal prompting? Yes No

If **YES** what amount of prompting do you give

.....

.....

Do you / does your client require assistance with fasteners? Yes No

Do you / does your client require assistance with shoes? Yes No

If **YES** please describe the assistance required

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.....

Please list any preferences you / your client have about dressing? *Eg. Shirt on before socks, particular colours*

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.....

Please list any other issues regarding dressing that you feel staff should be aware of

.....

.....

Are there any risks associated with dressing?

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.....

ACTIVITIES

What activities do you / does your client enjoy participating in?

Indoors:

.....
.....

Outdoors:

.....
.....

Do you / does your client enjoy using public transport? Yes No

Would you / your client enjoy trips out in a mini bus? Yes No

Do you / does your client suffer from travel sickness? Yes No

If **YES** please indicate how you manage this

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.....

Do any other problems arise from these activities? *(Please list)*

.....
.....

Do you / does your client use any aids when taking part in activities? *(Please list)*

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.....

Do you / does your client display any anxiety when part of a crowd? *(Please list)*

.....
.....

Are there any activities that you / your client do NOT enjoy? *(Please list)*

.....
.....

Do you / does your client mix well with other people? Yes No

Do you / does your client become distressed at loud noise? Yes No
Eg. Fireworks, fairgrounds

Do you / does your client enjoy assisting with simple tasks? Yes No
Eg. Laying the table, drying dishes

Are you / is your client aware of dangers in the kitchen? Yes No
Eg. hot surfaces, sharp knives

Do you use any special equipment? Yes No

If **YES** please detail below

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.....

Is there anything else you would like us to be aware of? Please include any risks that have not already been detailed.

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HEALTH NEEDS ASSESSMENT

Please complete as accurately as possible. Do you / does your client...

Have any known infections? Yes No

If **YES** state the known infection and how it is being treated

.....

Have any medical conditions that could arise? *Eg. Epilepsy* Yes No

If **YES** please state the problem and how you manage it

.....

Have any problems with:

Eyes / Sight Yes No

Ears / Hearing Yes No

General Movement / Balance Yes No

Co-ordination / using hands Yes No

Skin

Have sensitive skin? Yes No

Suffer from any skin disorders? *Eg. Eczema* Yes No

Eyes

Wears glasses? Yes No

Suffer from any eye infections? Yes No

Ears

Have any hearing problem? Yes No

Suffer from ear infections? Yes No

Nose

Suffers from any nasal sensitivity? Yes No

Bowels

Please state normal functions and normal colour, consistency etc. *Eg. frequently suffers from loose stools, constipation*

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.....

Urine

Have any urinary tract problem? Yes No

If **YES** please state

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.....

Have a regular toileting programme? Yes No

If **YES** please state what this involves

.....
.....

Wear pads? Yes No

If **YES** please tick a time frame

24 hours Night time only
Daytime only When outdoors

Breathing

Suffer from any breathing disorders *Eg. Asthma* Yes No

If **YES** please state condition and equipment or physiotherapy used *Eg. Inhaler*

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.....

Mobility

Are you / is your client fully mobile? Yes No

Can you / can your client weight bear? Yes No

Do you / does your client require use of a hoist? Yes No

Do you / does your client wear any body braces, splints etc.? Yes No

If **YES** please describe equipment used

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.....
.....

Do you / does your client use a wheelchair? Yes No

Do you / does your client require assistance with positional changes?
Yes No

If **YES** please give details

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.....

Equipment

Equipment used	Supplier	Responsibility for repair / replacement
.....
.....
.....

Do you / does your client suffer from epilepsy? Yes No

If **YES** please indicate how this affects you / your client. Are there any pre-seizure indicators? How often? At what stage medication is given? When is medical assistance sought?

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.....

Medical History

Please provide a brief medical history? *Eg. Operations, known conditions, allergies including risks*

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Sensitivities

Please indicate if you / your client is sensitive to noise, heat, cold, sun, water etc.

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Diet

Please indicate dietary requirements. In particular please specify where special feeds are obtained, methods of feeding, tubes and preferred feeding positions. Please detail wind position and associated management, equipment used, sterilisation, and whether tasters are allowed.

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.....

How is this behaviour managed?

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.....

Do you / does your client have any fears that the Centre staff should be made aware of?

Yes

No

If **YES**, please give details

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Are there any risks we need to be aware of?

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MEDICATION

Please list your / your client's prescribed medication

Name of Drug	Dosage	Time given
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.....

Does your client resist taking medication? Yes No

If **YES** please list any methods of encouragement that your client will respond to

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.....

Please specify below how medication is taken

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If medication is to be taken in place of food or drink we will need a confirmation letter from your / your client's GP

In what form is medication given as prescribed by the GP?

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Please list any identified restrictions of food or drinks when taking prescribed medication

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Are there any known allergic reactions to medication? *Eg. Penicillin*

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.....

Are there any risks associated with medication?

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CONSENT

To be completed by Parent / Guardian

I as the legal parent / guardian of
hereby consent to my son / daughter participating in the following activities while residing at the
Alan Shearer Short Break Centre:

PLEASE TICK AS NECESSARY

Swimming	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Walking	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Visiting parks	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Supervised use of park facilities (swings etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Visiting food outlets	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Watching watershed television	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Watching appropriate videos	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Supervised indoor activities (water play, painting etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Seaside	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cinema	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Application of sun cream	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bowling	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Out of area social trips	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Travelling on mini bus	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Horse riding	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Photographs	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sharing photographs	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Promotion videos (for St Cuthberts Care only)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

The above list has been fully explained to me and I understand that all physical activities will be undertaken following a complete risk assessment and only with staff supervision.

Signed Date

Witnessed by

Declaration

I confirm that I have disclosed all necessary and relevant information regarding my / my client's needs. I understand that the information completed in this questionnaire will remain confidential and will be used to develop a complete care package suited to my / my client's needs.

Signed by Parent / Guardian

Signed by Staff Member

Date

MEDICAL CONSENT

Name of User

Project Alan Shearer Short Break Centre

Date of Birth

I understand and agree that if recovery medication such as Buccal Midazolam is prescribed that it will be given in line with the agreed Individual Seizure Management Plan

Yes No N/A

I hereby consent to the staff administering all prescribed medication to the above named person in line with the MAR sheet and current written instruction from a GP or other medical professional

Yes No N/A

I hereby consent to first aid treatment being given for minor injuries (*Scratches and scrapes etc.*)

Yes No

I hereby consent to homely medication being given as listed (*Eg. Paracetamol, Calpol*)

Yes No N/A

Please list as required

.....
.....

In the event of medical, dental or surgical treatment (including the administration of local or general anaesthesia in an emergency) being required, I hereby give my consent to any treatment that is considered necessary by the medical advisors

Yes No

Signed by Parent / Guardian / Responsible Person

Signed by Service User

Date

If there is any information that you feel has not been discussed and that staff should be aware of, please detail below

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.....
.....

FUNDING AGREEMENT

Please complete this section of the form to confirm who will be paying for your stay at the Alan Shearer Short Break Centre.

Please note that rates will be reviewed annually in April and will rise in line with annual rate of inflation.

Payment must be made upon receipt of invoice.

Type of Funding Agreed (*Please tick*)

Direct Payments Individualised Budget Social Care

Health Authority Self Funded Other

If **Other** please specify:

Allocation Agreed (*Please tick*)

Financial Year Calendar Year Set Period

If **Set Period** please specify:

Billing Details (*Please complete*)

Name of Addressee

Job Title

Invoicing Address

..... Post Code

Signature on behalf of Agency / Authority / Carer

Date

Signature on behalf of St Cuthberts Care

Name

Job Title

Date

I am aware that the Alan Shearer Short Break Centre has a fob entry system, which is used throughout the building to ensure the safety of all guests. This is not used to deprive anyone of their liberty, but as a safety measure. Guests are free to come and go in accordance with their individual risk assessments.

There are alarms used on bedroom doors. These can be turned on or off as required and are used to alert staff if the door is opened, ensuring the staff are aware of the whereabouts of all guests.

The Centre has a small number of portable monitoring cameras which can be used if required. This is usually to monitor seizure activity and would be used discreetly and in accordance with individual risk assessments.

I agree to these methods being used during
stay at the Alan Shearer Short Break Centre.

Name.....

Position

Date