



**BCA Support Services**  
Supported Living

**411 – 421 Coventry Road  
Birmingham  
B10 0TH  
www.bcasupport.com**

**NEW CLIENT REFERRAL FORM: CONFIDENTIAL**

<b>REFERRAL DETAILS</b>	
DATE OF REFERRAL:	NAME OF REFERRER:
FULL NAME:	KNOWN AS:
DATE OF BIRTH:	AGE:
MARTIAL STATUS:	GENDER: M/F
ADDRESS:	NI NUMBER:
RELIGION:	TELEPHONE NO: MOBILE NO: MOBILENO:
RELIGIOUS REPRESENTATIVE NAME AND CONTACT DETAILS:	CULTURAL BACKGROUND/ETHNICITY:
NEXT OF KIN:	RELATIONSHIP:
ADDRESS:	TELEPHONE NO:
GENERAL PRACITIONER (GP) NAME:	CARE CO-DRDINATOR/TEAM MANAGER NAME:
ADDRESS:	ADDRESS:
TELEPHONE:	TELEPHONE:





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REFERRING TEAM e.g. HTT, EIS AOT, CMHT,	SOCIAL WORKER NAME:
ADDRESS:	ADDRESS:
TELEPHONE NO:	TELEPHONE NO:
CONSULTANT:	LEGAL STATUS:
NAME:	NAME:
ADDRESS:	ADDRESS:
TELEPHONE NO:	TELEPHONE NO:
OTHER CARE WORKERS INVOLVED I.E CARE WORKER SOCIAL WORKER ETC:	NAME:  ADDRESS:  TELEPHONE NUMBER:
REASON FOR REFERRAL:	WHAT ARE YOU HOPING FOR FROM THE SERVICE USER STAY IN BCA SUPPORT SERVICES AND HOW LONG DO YOU EXPECT THE SERVICE USER TO STAY:

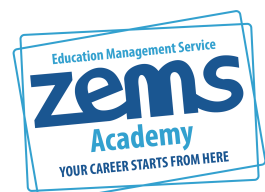




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<p>HAS THE SERVICE USER EXPRESSED ANY VIEWS ABOUT COMING TO BCA SUPPORT SERVICES:</p>	<p>PRESENTATION AT TIME OF REFERRAL (INCLUDING ANY RISK ISSUES)</p>
<p>CURRENT MEDICATION:</p>	<p>DAILY LIVING SKILLS/TRAINING NEEDS DOES THE SERVICE USER EXPERIENCE DIFFICULTIES WITH THE FOLLOWING? COOKING YES/NO PERSONAL HYGIENE YES/NO OTHER (IF SO PLEASE STATE DETAILS BELOW):</p>





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### **SPECIAL CIRCUMSTANCES**

To your knowledge and in order for us to facilitate this person's stay at BCA are there any other significant factor/s that might be relevant to this individual's care:

e.g.

Do they have any mobility difficulties?

Do they have any particular language or communication needs?

Are there any surrounding issues relating to significant people in their life such as access to children, domestic violence etc?

Are they pregnant?

Are there any other Care Workers involved?

Are there any specific religious/spiritual needs?

### **THE FOLLOWING DOCUMENTATION WILL NEED TO BE COMPLETED AND ATTACHED, TO ENABLER THE REFERRAL TO BE PROCESSED.**

- HEALTH AND SOCIAL CARE ASSESSMENT
- CURRENT CARE PLAN DOCUMENTATION TO INCLUDE RISK HISTORY
- THE CURRENT AND COMPLETE FULL RISK ASSESSMENT





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**TO BE SIGNED BY THE PERSON MAKING THE REFERRAL**

SIGNATURE:

PRINT NAME:

JOB TITLE:

CONTACT DETAILS:

TELEPHONE:

EMAIL:

DATE:

ANY ADDITIONAL INFORMATION:





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**PLEASE SEND IN ALL REFERRALS TO:**

**[referrals@bcasupport.com](mailto:referrals@bcasupport.com)**

