|  |  |
| --- | --- |
| **Client information** | **Case Manager details** |
| **Referral Date:** | **Case Management company**:  |
| **Name:**  | **Case Manager’s name**:  |
| **Age:** **DOB:**  | **Contact number**:  |
| **Female** [ ]   **Male**  [ ]   | **Email address**:  |
| **Client’s current address:**  | **Business address**:  |
| **Client’s contact number:**  | **Authorised Funder/Solicitor** |
| **Client’s email address:**  | **Business name**:  |
| **Does the client have capacity? Yes**  [ ]   **No** [ ]   | **Solicitor’s name**:  |
| **If no, then please provide details:**  | **Contact number**:  |
| **Next of Kin details**  | **Contact email**:  |
| **Next of kin:**  | **Address**:  |
| **Relationship to Client:**  | **Postcode**:  |
| **Next of Kin Contact details:**  | **Who should receive invoices?** |
| **Client’s current location/address** **Home** [ ]  **Residential** [ ]  **Hospital**  [ ]  | **Is the support privately funded? Yes**  [ ]   **No** [ ]   *If yes please provide details:* |
| **Are there other professionals involved? Yes**  [ ]   **No** [ ] *If yes, then please provide details below.* | **Are there other support workers involved?**  **Yes**  [ ]   **No** [ ] *If yes, then please name them and their organisation(s) below.* |
| 1.  | 1. |
| 2.  | 2. |
| 3. | 3. |
| **History***Please provide details about the client’s injury and medical history below.* |
|  |
| **Support Worker requirements**  |  |
| Female [ ]  Male [ ]  | **Preferred support worker age:**18-24 [ ]  25-36 [ ]  37-45 [ ]  45+ [ ]  N/A [ ]  |
| Will personal care be required? **Yes**  [ ]   **No** [ ]  *If yes, then please provide details below:*  | Is a driver required? Yes [ ]  No [ ]   |
| **Other qualities/interests required:** |
|  |
| **Client’s support needs** |
| **Emotional needs:** | **Social Skills:** |
| **Motivation:** | **Cognitive difficulties:** |
| **Social Skills:** | **Challenging or aggressive behaviour:** |
| **Independent living skills:** | **Budgeting and finance:** |
| **Medication** | **GP details** |
| **Any known food and/or drug allergies? Yes**  [ ]   **No** [ ] *If yes, then please provide details below:*  | **Name:**  |
|  |
|  | **Address:**  |
|  |
|  | **Contact Details:**  |
|  |
| 1. You will be allocated a package manager who will manage the daily running of your client’s support package.
2. We ask that you please contact your package manager directly for all daily support management queries.
3. We ask that all invoices will be sent weekly to be paid within 7 days of the invoice date.
4. We ask that all finance queries and updated information are communicated to your package manager in a reasonable time after receiving an invoice.
5. Please communicate any finance queries directly with the accounts department at karl.thompson@thcs.co.uk. By signing this document, you agree that the information provided to Thompson Holistic Care Services (THCS) is correct when this form was completed, and that any changes will be communicated to us immediately. Thank you.
 |
| **Referral form completed by:**  |
| **Date:**  |
|  |
| **Please password-protect and email your completed referral form to** **karl.thompson@thcs.co.uk****, thank you. We will respond to your referral request within 24 hours. For further enquiries, please contact us via our details below.** |