

Please complete this form with as much detail as possible and rename and save this document with the initials and date of birth of the person being referred**.**

**Please note\* An initial assessment will be required and a quotation for this will be given after a telephone consultation.**

**Farm Assistant Details (Please fill this in about the person that is being referred.)**

| Title:  |
| --- |
| Surname: |
| First Name(s): |
| Date of birth: |
| Address: |
| Postcode: |
| Date of birth:  |
| Birth Gender: |
| Pronouns used if different from birth: |
| Nationality: |
| GP Name/Address: |
| Does the farm assistant been referred consent to this referral? ☐ Yes ☐ No  |

**Education provider referral**

| Is this referral from an education provider?☐ Yes – please complete this section and other referrers section with home details. ☐ No – please skip to the next section |
| --- |
| Name: |
| Role: |
| Setting: |
| Address: |
| Phone number:  |
| Email: |
| Who will be funding the referral and sessions: |
| Please provide contact emails for the following to be shared with:Finance/invoicing:Purchase order no:Attendance records:Key point of contact: |
| Will you be required to visit the farm assistant in this setting: ☐ Yes ☐ No (If so, how often will you visit) |

**Other referrers/ Self-referral**

| What is your relationship to the individual being referred: |
| --- |
| Name: |
| Setting (if applicable): |
| Role (if applicable): |
| Address: |
| Phone number:  |
| Email: |
| Length of time you have known the individual: |
| Who will funding the referral and sessions: |
| Please provide contact emails for the following to be shared with:Finance:Attendance records:Key point of contact: |
| Will you be required to visit the farm assistant in this setting: ☐ Yes ☐ No(if so, how often will you visit) |

**Weekly Routine**

| Please give details of the individuals routine and commitments (*We will do our best to work around your current schedule however due to a large waiting list this cannot be guaranteed)* |
| --- |
|  | Mon | Tues | Wed | Thurs | Fri |
| Morning |  |  |  |  |  |
| Afternoon |  |  |  |  |  |
| Additional Comments: |

**Details of referral**

| Do you want to refer the individual for: ☐ Non - Clinical Occupational Therapy Assessment  ☐ Regular Therapy Farm Sessions ☐ Community Therapy Sessions ☐ Unsure (we will contact you to discuss what is most suitable for your referral) |
| --- |
| Please tell us about the person being referred. (This should include but not limited to any diagnosis/medical condition(s) and Mental health history, communication needs and how these factors impact on day-to-day life.) |
| Please list all medication currently being taken and why (including any side effects) |
| Please describe level of mobility  |
| Does the person being referred have any known allergies? (Please advise if an EPI pen or similar may be required.) |
| Does the person being referred have a history of substance misuse or an offending history: (Please include outstanding offences not yet charged and any involvement with cruelty to animals) |

|

| Tick the following areas of interest. ☐ Animal care ☐ Dog walking/training  ☐ Gardening ☐ Arts and Crafts ☐ Woodwork ☐ Conservation |
| --- |
| Hobbies: (Give details of the individuals likes and interests and how often they engage in these) |
| What are your future goals and how can we assist you to reach them?(Please supply any previous Occupational Therapy or other reports.) |
| Are you currently in Education? If so where and how often do you attend (include detail of tutor, home education or alternative provisions) |
| Do you have an education plan? (If yes, please provide a copy to support referral) |
| Please provide details of any other service involved (e.g. social services, other provisions) |
| Please provide any other information we should be aware of (e.g. fear of animals, family history, triggers, behavioral difficulties) |
| How did you hear about our service? |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |

**Emergency Contact**

| Emergency contact name and address: |
| --- |
| Emergency contact telephone number: |
| Emergency contact relationship to the referee: |

**Consent**

| **Privacy Policy (GDPR)**Dedham Therapy Farm CIC is committed to protecting and respecting your privacy. We are responsible for protecting your personal information as a “data controller” under applicable data protection legislation. To view our Privacy Policy please see our website [www.dedhamtherapyfarm.org](http://www.dedhamtherapyfarm.org)  ☐ I declare that the information I have given in this referral is, to the best of my knowledge and belief, true and correct. I also agree with the information on this form being stored by Dedham Therapy Farm CIC under their privacy policy. |
| --- |
|  ☐ I consent to information being shared with and gathered from all services named in this form. |
| Sometimes Dedham Therapy Farm would like to contact you to promote the service and to increase awareness about what the Farm offers, please specify if you wish to be contacted by Dedham Therapy Farm CIC for marketing purposes.  ☐ I wish to be contact by Dedham Therapy Farm CIC ☐ I do not wish to be contacted by Dedham Therapy Farm CIC |
| Name |  |
| Date  |  |
| Signature  |  |

Please bear with us while we process your referral. We are currently experiencing a high number of referrals. We endeavor to contact you upon receipt of the completed form, however if you haven’t heard from us and would like to confirm we have received your form please call us.