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**Spinning World referral form**

**Information about the person you are referring to us:**

**To be filled out electronically**

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|  | **Consent to refer;** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | NHS No. |     | - |     | - |      |  |
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|  |  |  |  |  |  |  | Before making the referral please make sure you have: |  |  |  |  |  |  |  |
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|  |  |  |  | • Met with the individual being referred to Spinning World ALW  |  | Please tick |[ ]   |  |  |  |
|  |  |  |  | • Gained consent from the individual to refer  |  | Please tick |[ ]   |  |  |  |
|  |  |  |  | • Consent for information to be stored on the secure PSS database |  | Please tick |[ ]   |  |  |  |
|  |  |  |  | • Checked with the client which language they would like therapy in |  | Please tick |[ ]   |  |  |  |
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|  | **Client’s details:** |  |  |  |  |  |  |  |  |  |  |  |  |  | **Additional requirements:** |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Language spoken |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Title | Choose an item. | Other: |  |  |  |  (1= preferred language in therapy): |
|  | First Name |       |  |  |  | 1st |  Language | 2nd |  Language |  |
|  | Surname |       |  |  |  | 3rd |  Language | other |  |  |
|  | DOB | Enter Date of Birth |  |  |  | Is an interpreter required? | Please tick |[ ]   |
|  | Country of Origin |       |  |  |  | Disability? |  |  |  | Please tick |[ ]   |
|  | How does the child describe their |  |  |  |  |  |
|  | Gender | Choose one please. |       |  |  |  |  |  |
|  | How does the child describe their |  |  |  |  |  |
|  | Sexuality | Choose one Please |       |  |  |  |  |  |
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|  | **Clients contact details:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | Address |       |  |  |  | Tel no |       |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  | Mobile no |       |  |  |
|  |  | Postcode |      |  |      |  |  |  |  |  |  |  |  |  |  | Email |       |  |  |
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|  | **RISK ASSESSMENT**Are you aware of any risk to PSS Seedlings staff during visits to the home, i.e. domestic violence, antisocial behaviour, pets? If yes, please give details |  |
|  |       |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Preferred Gender of Therapist | Choose an item. |  | Preferred Gender of Interpreter | Choose an item. |  |
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|  | Ethnicity | Choose an item. |  | Other |  |  |
|  | UK Status | Choose an item. |  | Other |  |  |
|  | Religious Beliefs | Choose an item. |  | Other |  |  |
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|  | **GP details:** |  |  |
|  | GP practice name |       |  |
|  | GP name |       |  |
|  | Surgery address |       |  |
|  | Phone no. |       |  |
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|  | **Reason for Referral:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Any additional information / other requirements**:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Are there any current identifiable risks (to self or others) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | **Professionals Involved** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Currently accessing |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Historic access |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | What was the outcome |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | **Referrer Details** |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **Date Referred** | Click here to enter a date. |  |
|  | Name |       |  |
|  | From (Agency, ect) |       |  |
|  | Job Title |       |  |
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|  |  |  | **Send referral to: Fax 0151 702 5566 or e-mail** **AshtonLeighWigan@pss.org.uk** |  |  |  |
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