mares
community care farm

Old Amersham Farm
High Street
Old Amersham
Bucks HP7 0HR

Tel: 01494 728936
Mob: 07837 488051
Email: info@marescharity.co.uk

AGENT REFERRAL FORM

Date of Referral:	

Please note:
An assessment will be carried out at Mares and a trial period of 4 weeks is to be completed before the offer of a place is confirmed.

SERVICE USER INFORMATION	
Name:	Male / Female
Date of birth:	Email:
Phone:	Mobile:
Address:	Town:
County:	Postcode:

EMERGENCY CONTACTS
In the event of an incident who should we contact? E.g. Relative; mental health or social worker, friend. Please give 2 contacts:

First Contact Name:	Relationship:
Phone:	Mobile:
Address:	Town:
County:	Postcode:

Second Contact Name:	Relationship:
Phone:	Mobile:
Address:	Town:
County:	Postcode:

GP CONTACT	
Doctor's Name:	
Surgery Address:	Town:
County:	Postcode:
Phone:	Email:

REFERRAL AGENT INFORMATION	
Name of Referrer:	Job Title:
Organisation:	Email:
Phone:	Mobile:
Address:	Town:
County:	Postcode:

KEY WORKER INFORMATION		
Name of Key Worker:	Job Title:	
Organisation:	Email:	
Phone:	Mobile:	
Address:	Town:	
County:	Postcode:	
Do you have regular contact with the service user? Yes / No		How often?:
What other groups/organisations does the service user attend?		

REFERRAL INFORMATION
Please tell us why you are referring this person:
What does the person hope to gain by attending Mares:
How does this link with the person's care plan and goals for recovery? (Please attach a copy of the care plan):

HEALTH CONDITIONS				
Disability Category (Please tick):	Autistic Spectrum Disorder	Mental Health	Learning Disability	Epilepsy
Diagnosis (Please attach a risk assessment):				
Does the person have any medical conditions that staff at Mares need to know about (e.g. allergies; asthma; epilepsy; etc.):				
What physical health issues may impact on the person's ability to undertake activities at Mares:				
Is there anything else you think we should know:				

SIGNATURE	
Signature of referral agent:	Date:

Thank you for completing this form.
Please return it together with a copy of the care plan and a risk assessment to the above address.

FOR OFFICE USE ONLY	
Initial visit date:	Attended: Yes / No
Assessment date:	Competed: Yes / No
Start date for 4 week trial period:	Competed: Yes / No