Ponthafren Association Referral Form

Name of Person Referred:	Date Of Referral:	Is the client aware of the referral ☐ Yes ☐ No
Date of Birth:	Gender:	Ethnic Origin:

Address Line 1:

Address Line 2:

Address Line 3:

Postcode:

Home Tel No:

Mobile Tel No:

E-mail:

Can we leave a message on the number you have provided? ☐ Yes ☐ No

Please state any further instructions *(e.g. you can leave a message with a family member):*

Referring Agency:

Workers Name & Role:

Tel No:

E-mail:

Postcode:

Please return this completed form by email to: admin@ponthafren.org.uk
or return this form to:
Ponthafren Association, Longbridge Street, Newtown, Powys, SY16 2DY
For more information please contact 01686 621586

www.ponthafren.org.uk

Reg Charity No.: 1035326

Nature of the Referral *(Please tick the appropriate box)*

☐ Counselling ☐ One-to-One Recovery Project ☐ Befriending Project ☐ General Support ☐ Volunteering ☐ Work Experience ☐ Work Placement	**Life Skills Group Courses** ☐ Anger Management ☐ Confidence Building ☐ Resilience Skills ☐ Conflict Resolution ☐ Assertiveness Training ☐ Emotional Well-Being ☐ Coping with Change ☐ Managing Stress ☐ Decision Making ☐ Time Management ☐ THRIVE Mental Well-Being	**One to One Life Skills Courses** ☐ Anger Management ☐ Confidence Building ☐ Resilience Skills ☐ Conflict Resolution ☐ Assertiveness Training ☐ Emotional Well-Being ☐ Coping with Change ☐ Managing Stress ☐ Decision Making ☐ Time Management

Other, please specify:

Please state the reason & any relevant additional information below:

Counselling

(Please complete this section only if this is a referral for counselling)

Would they prefer daytime or evening appointments?

Are they available for weekend appointments? ☐ Yes ☐ No

Do they have a preference of counsellor?

Have they had counselling before? ☐ Yes ☐ No

If yes, who with?

One to One Support

(Please complete this section only if this is a referral for One to One Support)

Have they had previous One to One Support? I.e. DIY Futures, Hafal: ☐ Yes ☐ No

If yes, who with?

Do they have a CPN or social Worker? ☐ Yes ☐ No

If yes, who with?

Risk:

Are there any known risks or triggers that Ponthafren should be aware of, please fill in as much detail as possible below?

Associated Risk Factors *(please tick if applicable)*

☐ Substance / Alcohol Misuse

☐ Suicidal Ideation / Intent

☐ Violence / Aggression

☐ Self-Harm

☐ Self-Neglect

☐ Arson

☐ Inappropriate Behaviour

☐ Offending History

☐ Other, please tell us what:

Associated Risk Factors or Useful Information:

Please sign to say you have filled in the section overleaf to give a true reflection of any known risks that the client you are referring may pose to staff, volunteers, vulnerable adults that use our service. Failure to disclose this information is in breach of Health and Safety. If your agency holds a current risk assessment on the client you are refereeing please ensure you inform Ponthafren, during the referral process.

Name:

on behalf of: *(referring agency)*

Job title: Date:

Is the client required to attend appointments for a specific order? i.e. court order:

☐ Yes ☐ No

If yes, does the referring agency need to be informed of nonattendance at appointment?

☐ Yes ☐ No

If yes, please give name of agency contact person here:

Do they have any problems or needs and if so how are they affecting them?

☐ Sensory Loss

☐ Mobility

☐ Problems with reading or writing

☐ Anxiety

☐ Medical Conditions

☐ Allergies

☐ Other, please tell us what:

Is the person being referred a member of Ponthafren? ☐ Yes ☐ No

If not, how did they hear about Ponthafren?

Completed By: Date:

The section below is for Ponthafren Association use only

Date Of Referral:

Key Worker:

Has Membership been completed? ☐ Yes ☐ No

Has referral been passed onto appropriate department?

Code:

Notes:

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