spaceinclusive
Support for adults with LD and ASD

Space Inclusive - Initial Referral

An Initial Referral is our way to gain a perspective from as many different angles as possible on what works best for the individual. Please include details relating to home life, health and wellbeing, dangers and triggers, future wants and wishes, and physical health support needs. This information will help us to ascertain the most suitable Space Inclusive site for your individual and their specific support requirements.

Referrer Details						
Referring organisation:						
Name of referrer:		Date of referral:				
Referrer contact details:						
Client Details						
Name:		D.O.B:		Gender:		
Address:						
Contact Numbers:	Home:	Mobile:				
Parent/carer/other advocate name(s):						
Parent/carer/advocate contact details):						
Current placement, if so, where:						
Days preferred/required (Please circle)	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	Total Number Days: …….
Setting preferred/required (Please circle)		*Space Inclusive		Community Outreach		
We will contact you following assessment of this form to arrange an initial viewing.						
Diagnosis details:						
Consent and Mental Capacity						
Does the person have capacity to make a decision regarding attending Space Inclusive?						
If the person is unable to consent to attending Space Inclusive, is there evidence of consultation in making a best interests decision?						
Have the views of people engaged in caring for the individual e.g. family, carers, CLDT been sought? Please record the names and views of those consulted.						
Communication						
Communication issues:						
Communication methods currently used e.g. BSL, Makaton:						
Behaviour triggers around communication						

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Support Requirements		
Communication needs *Please tick all that apply*	Makaton	☐
	EAL (English as Additional Language)	☐
	Visual Timetable preferred	☐
	British Sign Language (BSL)	☐
	Visual Impairment – if so please specify needs	☐
	Hearing Impairment – if so please specify needs	☐
Personal Care needs	Is personal care required?	Yes ☐ No ☐
	If yes, is a particular member of staff preferred?	Male ☐ Female ☐ Either ☐
Travel	Can the client travel independently?	Yes ☐ No ☐
	Does the client have a bus pass?	Yes ☐ No ☐
	If yes, does it include a companion pass?	Yes ☐ No ☐
	Has the client participated in travel training before?	Yes ☐ No ☐
Behaviours of Concern *Please give details of any behaviours of concern(including triggers and strategies/techniques for managing the behaviour)*		
Health and Fitness	Does the client have mobility issues?	Yes ☐ No ☐
	If yes, does the client require the use of a mobility aid? ie, wheelchair, rotunda, walker, cane, please give details:	
	Does the client have any physical impairments which may affect their ability to participate in health and fitness related activities? i.e. muscular skeletal conditions which affect joints, bones, and muscles i.e. arthritis, osteoporosis, please give details:	
Other Support Needs		

Additional Information

IMPORTANT: **Please attach current/last EHCP, current/last Care Plan, any current/last professional medical assessments or reports.**
Please indicate by marking the box X :

Documents Attached ☐

No Further Documents ☐