

VISION 21 (CYFLE CYMRU) STUDENT REFERRAL FORM

ALL sections of this form must be completed in full.

Incomplete information will delay the opportunity of a student placement.



STUDENT INFORMATION					
Surname		First Name		Date of Birth	
Address					
Town/City		County		Postcode	
Phone No		Alternative Phone No			
Email		Nationality		Ethnicity	
National Insurance No		Male	<input type="checkbox"/>	Female	<input type="checkbox"/>
What is your first language?			What is your religion?		
What school did you last attend?			When did you leave school?		
I do <input type="checkbox"/> / I do not <input type="checkbox"/> agree to have photographs taken and used for student records and/ or promoting the projects. Please sign					
PLEASE TELL US ABOUT THE PERSON REFERRING THIS STUDENT					
Name of Referrer			Telephone / email		
Address					
Social Worker/ Key Worker Name			Referring Agency (if applicable)		
Person or Team responsible for payment of placement fees			Signature (to agree to pay costs/ provide a contract)		
OUR PROJECTS					
a) Please indicate how many days per week you require	1	2	3	4	5
b) What are your preferred days?	Monday	Tuesday	Wednesday	Thursday	Friday
PROJECT PREFERENCES					
Catering			Card/ Craft		
Wood work			Pottery		
Office Skills/ ICT			Horticulture		
Retail			Animal Husbandry		
Training and Mentoring					

MEDICAL DETAILS

Do you have a specific learning disability or difficulty? YES NO

If you have answered 'yes', please state your condition(s):.....

Are you registered disabled? YES NO

Is your tetanus immunisation up to date?

YES NO If you have answered 'yes', please give the date:

(please note, a tetanus immunisation is a requirement for work in garden projects but we recommend that all students attending any Vision 21 Project have up to date immunisation)

Care plan is attached: yes no If no, please give details

(please note that if care plans have been completed over six months ago then we require them to be counter-signed with a recent date to confirm their current validity).

Please sign to give consent to contact ambulance/ paramedic services in an emergency.

Signature:.....

What is your level of disability?

MILD MODERATE SEVERE UNKNOWN

Please tick if you live with any of the following conditions:

Asthma (mild or chronic) or any other respiratory problem	<input type="checkbox"/>	Migraine	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	Eczema, dermatitis or skin rashes	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	Allergies or sensitivity	<input type="checkbox"/>
Heart problems (mild or chronic) or pacemaker	<input type="checkbox"/>	Speech problems	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Deafness	<input type="checkbox"/>
Bowel or bladder complaints	<input type="checkbox"/>	Use of a hearing aid	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Use of sign language	<input type="checkbox"/>
Thyroid gland disorder	<input type="checkbox"/>	Problems with vision	<input type="checkbox"/>
Back or disc problems	<input type="checkbox"/>	Use of glasses or contact lenses	<input type="checkbox"/>
Sciatica	<input type="checkbox"/>	Phobias (fear of anything)	<input type="checkbox"/>
Foot, leg or lower body joint problems	<input type="checkbox"/>	Depression or anxiety	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>		
Hand, arm or upper body joint problems	<input type="checkbox"/>	Use of regular medication	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Wheelchair user or mobility problems	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	Blackouts or giddiness	<input type="checkbox"/>

If you have ticked any of the above, please provide further details

Please give details of any allergies (this is especially important for work in catering projects)

Details of medication and seizure or other medical protocols are attached. Yes No
If no, please give reasons

PERSONAL PROFILE			
The following details are highly important in order to arrange a suitable placement.			
BEHAVIOURAL & LEARNING DETAILS	YES	NO	DETAILS
Is there anything that can cause anger or aggression?	<input type="checkbox"/>	<input type="checkbox"/>	
Are there any behavioural management plans in place e. g. Positive Behaviour Management or other	<input type="checkbox"/>	<input type="checkbox"/>	
Are there any behavioural issues which affect interaction with others?	<input type="checkbox"/>	<input type="checkbox"/>	
Details of behaviour management plans or protocols are attached. Yes No			
If no, please give reasons: Signed.....			
Does the individual require 1:1 support other than a Vision 21 instructor e. g. support with personal hygiene or at meal times (NB Vision 21 does not provide support with personal care)	<input type="checkbox"/>	<input type="checkbox"/>	
Does the individual get easily upset?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the individual sociable / friendly?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the individual smoke?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the individual have any alcohol related problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the individual need enlarged text?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the student able to use computers?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the student comfortable working on a 1:1 basis?	<input type="checkbox"/>	<input type="checkbox"/>	
What is the students learning ability / concentration?	BASIC <input type="checkbox"/> GOOD <input type="checkbox"/> EXCELLENT <input type="checkbox"/>		

Please Provide Further Information as Necessary

PLEASE PROVIDE DETAILS OF YOUR DOCTOR	
Doctor's name	
Doctor's address	
Doctor's telephone number	

PREFERRED WORKING CONDITIONS	YES	NO	DETAILS
Quiet	<input type="checkbox"/>	<input type="checkbox"/>	
Noisy / busy	<input type="checkbox"/>	<input type="checkbox"/>	
Warm	<input type="checkbox"/>	<input type="checkbox"/>	
Cool	<input type="checkbox"/>	<input type="checkbox"/>	
Male environment	<input type="checkbox"/>	<input type="checkbox"/>	
Female environment	<input type="checkbox"/>	<input type="checkbox"/>	
Working alone	<input type="checkbox"/>	<input type="checkbox"/>	
Working as part of a team	<input type="checkbox"/>	<input type="checkbox"/>	
Able to use safety equipment such as face masks, goggles, disposable gloves etc	<input type="checkbox"/>	<input type="checkbox"/>	
MOBILITY			
Wheelchair user			
Is able to stand unaided for a period of time			
Is able to walk a reasonable distance			
Please use this space to provide further information if necessary.			

Please provide information on how you plan to access Vision 21:

Mode of transport:

Taxi Firm:

Taxi Firm Telephone Number:

Who should we contact if there are problems with transport?

PLEASE LIST THE DETAILS OF <u>TWO</u> DIFFERENT EMERGENCY CONTACTS			
1. Full Name		Relationship to student	
Address			
Home telephone No			
Mobile telephone No		Alternative Phone No	
2. Full Name		Relationship to student	
Address			
Home telephone No		Alternative Phone No	
Mobile telephone No			

Before returning the form to us, please ensure that:

- ✓ **The Declaration of Information and the agreement to meet training costs are signed**
- ✓ **The consent for photography is completed and signed**
- ✓ **All medical details are provided, in particular details of medication and conditions – please be specific**
- ✓ **Further supporting information is attached to this form (if applicable) such as:**
 - **Care plan detailing other activities or employment**
 - **Levels of Numeracy and Literacy skills (reading and writing), certificates and awards achieved**
 - **Living arrangements (at home with parents, or supported accommodation)**

DECLARATION OF INFORMATION

Please read and sign the following declaration:

The information that I have supplied with this form is correct to my knowledge at the time of writing. I understand that any information that is found to be undisclosed at a later date could result in the termination or suspension of the student placement pending further investigation.

I understand that it is the referrers responsibility to inform Vision 21 of any change to the student's personal circumstances, for example medication, health information, contact telephone numbers, change of address, change of case manager etc.

PRINT NAME

SIGNATURE DATE.....

Please contact us if you have any queries about any aspect of completing this referral form or questions about our services.

Once completed, please return the referral form and all support information to:

Theresa Wood
VISION 21 (CYFLE CYMRU)
UNITS 10 -12 FIELDWAY
MAES Y COED ROAD
HEATH
CARDIFF, CF14 4HY

Tel. 029 20621194 Fax. 029 20692458
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