**IPS Employment Referral Form (Private & Confidential)**

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| **Referral Details** | | | | | | | | |
| **Referral Date:** Short date letter merged | | | | **Referrer Name:** Free Text Prompt | | | | |
| **Clinical/Care Team:**  Primary Care/GP North Somerset:  Primary Care/GP S. Gloucestershire:  Primary Care/GP Bristol: | | | |  | Referrer Address:  Organisation Full Address (stacked) | | | |
|  | | | |  | Email:  Organisation E-mail Address | | | |
|  | | | |  | Contact No:  Organisation Telephone Number | | | |
| **Key Criteria** | | | | | | | | |
| Service user is motivated to get paid employment | | | | | | | Yes | |
| Employment has been discussed with the Applicant? | | | | | | | Yes | No |
| **Service User Details** | | | | | | | | |
| Mr | Mrs | Ms | Other | | | Applicant Address: | | |
| Applicant Name: Given Name Surname | | | | | |  | | |
| Preferred Name: | | | | | |  | | |
| Rio No: | | | | | | Email:  Patient E-mail Address | | |
| Date of Birth: Date of Birth | | | | | | Contact No:  Patient Mobile Telephone | | |

**Please send completed referrals to** [**PrimaryCare@waythrough.org.uk**](mailto:PrimaryCare@waythrough.org.uk)

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| **Health and Support** | | | | | |
| *Please expand below on mental health issues that may be relevant to entering or retaining employment* | | | | | |
| **Mental Health:** | | | | | |
| **Secondary Support Needs** | | | | | |
| "Does the individual consider themselves to have a disability?” | | | Yes | No | |
| Does the individual have secondary health problems or difficulties? (Please tick all that apply) | | | | | |
| Visual/sensory |  | Learning disability (not ASD) | | |  |
| Physical impairment |  | No disability | | |  |
| Long term medical health condition |  | Not Stated | | |  |
| Does the individual have Secondary Support Needs? (Please tick all that apply) | | | | | |
| Drug or alcohol addiction |  | Personality Disorder | | |  |
| Autistic Spectrum Diagnosis |  | Eating Disorder | | |  |
|  | | Language or communication difficulty | | |  |
| Please expand below on Secondary Support Needs that may be relevant to entering or retaining employment | | | | | |
| **Secondary Support Needs - additional information:** | | | | | |
| **Other agencies involved in supporting the individual *(e.g. MAPPA , Social worker):*** | | | | | |

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| **Risk management** |
| Are there any risk factors (current or historic) which the Employment Specialist should be aware of before meeting with the client? |
| **Obstacles to Engagement** |
| Are there any barriers which may impact on the service user’s engagement with an employment advisor? (E.g. Social anxiety, symptom related etc.) |
| Transport (please specify any transport difficulties): |
| Other commitments *(e.g. family commitments and any regular activities):* |

|  |  |  |  |  |  |  |  |  |
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| **Protected Characteristics** | | | | | | | | |
| Age at Referral | Age | | | | | | | |
| Gender | Gender(full) | | Other | | | Not Stated | | |
| Gender Reassignment | Yes | | No | | | Not Stated | | |
| Sexual Orientation |  | | | | | | | |
| Marital Status | Marital Status | | | | | | | |
| Pregnant | Yes | No | | | Not Assessed | | | N/A |
| Ethnicity | Ethnic Origin | | | | | | | |
| Religion (or otherwise) | Religion | | | | | | | |
| Does the individual consider themselves to have a disability? | | | | Yes | | | No | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please TICK below to confirm items are present and up to date on Rio:** | | | |
| Risk Assessment | Core Assessment | | Crisis and Contingency Plan |
| **Client’s Signature:** | | **Date:** Short date letter merged | |
| **Referrers Signature**: *I understand that I am responsible for notifying my IPS Employment Specialist of any significant changes to information on this referral,* ***particularly relating to HEALTH or DISCHARGE FROM CLINICAL CARE.*** | | | |
| **Signature:** | | **Date:** Short date letter merged | |