**Case Management Referral Form**

Thank you for enquiring about our Case Management service.

**Please note our referral meetings are held twice a week.**

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| **Referrer Details** | |
| Date of referral: |  |
| Referrer contact name: |  |
| Referrer contact email address: |  |
| Referrer contact phone number: |  |
| Non-expert service being sought: | ☐ Case Management Immediate Needs Assessment only  ☐ Case Management Immediate Needs Assessment + Treatment |

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| **Client Details** | | |
| 1 | Client initials |  |
| 2 | Client Location |  |
| 3 | Client Age |  |
| 4 | Gender | ☐ Male ☐ Female ☐ Other |
| 5 | Client’s preferred language  Client’s ethnicity/cultural identity |  |
| 6 | Litigation Status | ☐ Settled ☐ Unsettled ☐ Deputy involved |
| 7 | Injury | ☐ Brain injury ☐ Spinal cord injury ☐ Orthopaedic injury |
| 8 | Any current concerns or risks? | ☐ No  ☐ Yes - monitored risks (please state):  ☐ Yes - social care involvement |
| 9 | Any care, therapy or inter-agency involvement at present? | ☐ No  ☐ OT ☐ Physio ☐ Psychologist  ☐ Care team ☐ SLT ☐ School/Workplace  ☐ NHS services ☐ Third sector ☐ Local Authority  ☐ Other (please state): |
| 10 | Have they had any case management before? If so, please provide details | ☐ Yes ☐ No  If Yes, please provide details: |
| 11 | Please provide brief detail of injury including month/year it happened  Please include how the client presents e.g. communication, mobility, cognitive impairment, emotions/mental health, behaviour, pain, fatigue etc |  |
| 12 | What are the main needs as far as you understand them?  Tick all that apply | ☐ Recruiting care/nursing team ☐ Managing care/nursing team  ☐ Home adaptations ☐ Sourcing a new home  ☐ IDT set up ☐ Reviewing IDT input  ☐ Mental health e.g. anxiety, depression, adjustment, grief, loss, PTSD  ☐ EHCP/educational support ☐ Challenges with family  ☐ Equipment ☐ Financial management  ☐ Liaison with statutory services ☐ Expert witness meeting support  ☐ Other (please state): |
| 13 | Please provide any further relevant information that could contribute to a positive therapeutic relationship eg hobbies, interests, preferences etc |  |
| 14 | Who lives with the client?  Please also state any animals in the client’s property |  |
| 15 | I would like to be kept up to date with service updates/blogs from PsychWorks Associates. I can unsubscribe at any time from within the update emails. | ☐ Yes |
| 16 | Where did you hear about PsychWorks Associates? | ☐ Word of mouth ☐ Social media ☐ Training event  ☐ Conference material ☐ Worked with PWA before  **If other please state:** |

**Please return the completed form to** [**admin@psychworks.org.uk**](mailto:admin@psychworks.org.uk?subject=Referral)

Please note:

Immediate Needs Assessments will be undertaken by our Lead Clinician. On occasion, to provide timely support, it might be recommended that the Lead Clinician undertake the assessment online with a cost-effective Associate providing face-to-face support to better inform the assessment of environmental factors.

In exceptional circumstances, PsychWorks Associates reserves the right to pause the assessment process if it is not deemed to be clinically appropriate at the current time. Full and thorough discussion would take place with the referrer prior to any such decision being made.

Pre-assessment ‘meet and greet’ sessions for engagement may be charged in addition to assessment cost, at the hourly rate plus Associates’ travel (if required to be face-to-face).

Any duty of care support that has arisen that was not anticipated e.g. safeguarding matters will also be charged at the hourly rates plus Associates’ travel.

Associate input will be available when agreement to funding has been provided, and signed terms of business are received from the commissioning parties.