A picture containing text, clipart

Description automatically generated

Email: **therapy@adotherapy.co.uk**

Website: [**www.adoservices.co.uk**](http://www.adoservices.co.uk)

**For Professionals Only - Please note that this model is only accessible for ADO Therapy service users that are KS3-Post 16 ages. It is a Short-Term Service (maximum one term) that aims for reintegration back into education from that point on. Once complete please attach any relevant documents and return securely to the email stated above.**

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| **ADO Therapy Day Service Referral Form** |

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| **Referrer Details** |  |
| **Name:** | **Job Title:** |
| **Agency:** | **Address:** |
| **Telephone:** | **E-mail:** |
| **Date of Referral:** | **Is this Referral to ADO:**  A Short-Term Interim Placement (for half a term)  A Medium-Term Placement (for half a term-one full term)  *Please note that we do not currently offer Long- Term Placements for our Therapeutic Day Service. If this is something you may require, please speak to us directly.* |
| **How long have you worked with this Person?** *(Please tick)*  Less than 6 months  1-2 years  6 months to 1 year  More | **In what capacity?** *(Please tick)*  Local Authority  Teaching Professional/Current School  CAMHS    Fostering Agency  Social Worker  Other (*please Specify)*: |

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| **Service User Details** | |  | |
| **Full Name:**  **Preferred Name: *(if different to above)*** | | **Gender Identity:**  Male  Female  Transgender  Non-binary/ non-conforming  Other | |
| **Date of Birth:**  *Please note this service is only available for KS3-Post 16.* | | **Telephone:** | |
| **School Year** *(if relevant):* | | **Key Stage** *(if relevant):* | |
| **Ethnicity** *(Please tick all which apply)***:** | |  | |
| White |  | Black or Black British |  |
| British |  | Caribbean |  |
| Irish |  | African |  |
| Any other white background |  | Other Black or Black British |  |
| Asian or British Asian |  | Other ethnic background |  |
| Indian |  | Chinese |  |
| Pakistani |  | Mixed ethnicity Other |  |
| Bangladeshi |  | Other *(please specify below)* |  |
| Not Declared |  |  |  |
| **Address:**  **Postcode:** | | **Service User’s UPN (if known)**: | |
| **Service User’s ULN (if known)**: | |
| **Is This Person Under:**  *(Please tick where applicable)*  Social Worker  Looked After Child (LAC)  Child In Need (CIN)  Sibling on Child Protection  Child Protection (CP)  Other: *Please State* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Please send any supporting documents at the time of referral).* | | | |
| **Does this person have a Safety Plan?**  Yes  No  Unsure  If ‘Yes’, please send the safety plan with the referral and any other supporting documents. | | | |
| **In your opinion, why would this person benefit from our Outdoor Therapy Services?** | | | |
| **How does this referral link with their current education plan?** *(if relevant)* | | | |
| **Please provide a brief educational overview for the service user:** *(we will not be working towards any educational outcomes, but an overview of academic capacity such as abilities to read and write will be very helpful for this service)* | | | |
| **In your opinion, have any specific psychological interventions been helpful in supporting this person? (***If yes please list which interventions and the timeline of when they were accessed)***.** | | | |
| **Would this person benefit from any specific embedded therapeutic workshops to increase their emotional resilience, well-being and coping skills?**  Yes  No  Unsure  *If ‘yes’, please tick below which ones;*  Managing Stress  Managing Depression  Managing Anger  Managing Anxiety  Developing Social Skills    Our model provides a combination of Cognitive Behaviour Therapy, Relaxation Therapy, Animal Therapy and Occupational Therapy to suit the needs of the service user and support their wellbeing. | | | |
| **Do you feel that this person will require regular sessions with one of our qualified therapists? Or are they accessing this from another service?** *(eg CAMHS, OXLEAS)* | | | |
| **How many therapeutic days per week are you referring for?**  *Please note we only offer this service on a* ***Monday*** *and* ***Tuesday****. We have limited spaces available and therefore we will offer any slots we have for your consideration (pending successful assessment).* | | | |

### **Clinical Details**

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| **Does the service user have an Education and Health Care Plan?**  *If ‘Yes’ please attach a copy of the care plan and send securely*  Yes  No  In Progress  **Does the service user have any professional reports such? (CAMHS/OXLEAS/EP etc)**  *If ‘Yes’ please attach a copy of the report and send securely*  Yes  No  In Progress |
| **Does the service user have any Medical Diagnosis?**  Yes  No  If ‘yes’, please detail:  **Does the service user require any medication administered during the therapeutic core day?**  Yes  No  Unsure  If ‘yes’, does the service user experience any side effects with this medication?  Yes  No  Unsure |
| **Please give a brief description of the service user’s mental health or behaviour**: |
| **Please give details of any intellectual difficulty or disability**: |
| **Please give details of any communication needs *(speech/language/hearing/sight)***: |
| **Please give details of any physical difficulties** *(strength, stamina, motor skills, mobility)*: |
| **Please detail any additional information which may be relevant, including family background**: |
| **Does the service user have up to date tetanus cover?**  Yes  No  Unsure |
| **Does the service user have a history in any of the following:** *(Please tick)*  **Self-harm or suicidal behaviour?**  Yes  No  Unsure  **Violence/ abusive behaviour towards peers?**  Yes  No  Unsure  **Violence or abusive behaviour towards staff?**  Yes  No  Unsure  **Violence or abusive behaviour towards animals?**   Yes  No  Unsure  **Arson?**  Yes  No  Unsure  **Absconding from provisions?**  Yes  No  Unsure  **Convictions as a young offender?**  Yes  No  Unsure  **Alcohol or drug misuse?**  Yes  No  Unsure  If any of the above applies please detail below: |
| The following is in relation to deterioration in the service user’s mental health.  **Please list any early warning signs/triggers**:  **How do you feel ADO can best support the service user?**  **How do you feel your client would like us to support them if their mental health was deteriorating?**  ***Note: If there are any changes with the service user’s mental health or medication, the referring organisation or caregiver would be required to let us know as soon as possible.*** |

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| **Emergency contact details for the service user:**  **Name**:  **Relationship**:  **Mobile Telephone**:  *(We use SMS or telephone calls to keep caregivers up to date on the service user (as required) so please provide a phone number where permission is granted for both SMS and calls during the therapeutic day)*  **E-mail**:  *If the caregiver that resides with the service user has any known additional needs or any information we should be aware of, in order to support them when liaising about the service user, please list any helpful information below:* |

**Assessment**

BILLING INFORMATION:

**Who will be funding the assessment/placement?**

Local Borough  School  Other *(Please Specify)*:

Invoicing Contact Name:

Invoicing Contact Job Role:

Invoicing Contact Phone Number:

Invoicing Email Address for E-Billing:

Invoicing Client Address for System Purposes:

*Please Note: All billing fields require completion for system setup and assessments to be booked.*

*The assessment consists of a digital form which is to be completed prior to us meeting the individual. This is classed as ‘Stage 1’ of our assessment process, followed by ‘Stage 2’ which is a two-day practical assessment. Please provide contact details for the most relevant person/s to undertake each part of the assessment.*

**Digital Assessment form:** *Our preference is for parent or care giver to complete this, as we have an understanding of professional’s viewpoint from this form. However, in some cases we know this is not feasible and therefore please list the most relevant adult:*

Name:

Relationship/Role:

E-mail:

**Practical Assessment Please note this service is available on Tuesdays and Wednesdays only currently.**

*(Maximum two adults; recommended one professional and one caregiver).*

*The supporting adults will be required for the first 2 hours of the first day assessment. If the service user settles within this time, they will be able to remain on site until the end of the therapeutic day. This allows staff to assess engagement and affirm we can safely meet their needs in the outdoor setting, before meeting them again for the second day.*

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|  | **Adult 1** | **Adult 2** |
| Name: |  |  |
| Relationship/Role: |  |  |
| Telephone: |  |  |
| E-mail: |  |  |

**Referrer’s Name - Signature:**

(Please note typed names will constitute signature for online referrals)

**Date:**

**Signature:**

Thank you for completing the ADO Therapy Day Service Referral Form.

Please send this referral and any supporting documents, such as EHCP, CIN plans, Safety plans, to:

[**therapy@adotherapy.co.uk**](mailto:therapy@adotherapy.co.uk)

If you have any questions, please call **020 8850 6778**

A member of the team will be in touch with you shortly.

Office hours 8.30 until 5pm

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