

CASIP
Ty Canna
40 Market Rd
Canton
Cardiff, CF5 1RZ

Tel: 07536090430

Office Use Only
Date for meeting:
Approved Yes <input type="checkbox"/> No <input type="checkbox"/>
Signature:
Date:

Referral Form for Cardiff Adult Self-Injury Project (CASIP)

This information will remain confidential and only be used by CASIP to support the client. Within 4 weeks of your referral being received by CASIP you will be contacted by a core member.

Section 1 and 3 are to be completed by the **referrer**:

Section 1 - Referral Information:	
Referral Date:	
Referrer Name:	Referrer Address:
Relationship to client: (Please state your job title if you are a Professional working with this client)	Contact details: Phone:- Email:-
Client Background Information: Name and Address:	Contact details: Phone:
Other information: (allergies/disabilities/special needs/medication/health problems: Please use an additional sheet if necessary.)	
Has the person been made aware of the referral? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Reason for referral (Please give a short description as to why you feel our service would benefit this person):	
Other key people involved in supporting the client:	
1. GP Name and Address:	Contact details: Phone:- Email:- Primary Care Trust:-
2. Name and Address: (Job title/organisation/agency name)	Contact details: Phone:- Email:-
Please state the support that the client needs from our service:	
Additional Information: (Please attach any additional sheets of information we may find useful)	

Section 2 and 3 are to be completed by the **client**:

Section 2 - Client Information:		
Client Name and Address:		Contact details: Phone:- Email:- Preferred contact method:-
Date of birth:	Age:	Gender:
Other information: (Allergies/disabilities/special needs/medication/health problems)		
Reason for Referral: (Please state how CASIP would be useful for you)		
Key Support Currently Available:		
1. GP Name and Address:		Contact details: Phone:-
2. Next of kin: Name:- Relationship to you:- Address:-		Contact details: Phone:-
What support would you be looking for from our service?		

Section 3 is to be completed by the referrer and client.

Section 3 – Confirmation and Signatures:	
Referrer: I have completed the above form accurately to the best of my knowledge.	
Signed:	Date:
Profession:	
Client: I have completed the above form accurately to the best of my knowledge.	
Signed:	Date:

Please post this completed form back to: - CASIP Referrals, Ty Canna, 40 Market Rd, Canton, Cardiff, CF5 1RZ. **Please note** that we **can not** accept referral forms where the referral section has not been completed and signed by an appropriate professional.

Web - www.casip.org.uk

Email – info@casip.org.uk

Tel - 07536090430