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| **St. Elizabeth’s Centre Application & Initial Assessment Information** |
| Name: |  | I like to be known as: |  |
| Current Address: |  | Service/s Required:(Please tick those that apply) | **Adult Services**ResidentialSupported Living Day Services  |
|  | **College**Education & Supported Living Education Only  |
|  | **School**Education & Children’s Home Education Only  |
| DOB: |  | Requested Admission Date: (Month & Year) |  |
| Contact Number/s: |  | National Insurance Number: |  |
| Ethnicity: |  | Nationality: |  |
| NHS Number (*if known*):  |
| **Are you subject to a Home Office deportation order?** Yes / No |
| **Are you able to provide proof of eligibility for funding purposes, for example passport?** Yes / No |

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| Funding Authority (Social Services, CCG, private etc.): |  |
| Named Contact Person & Address: |
| Telephone Number: |
| E-mail Address: |
| Name of SEN Representative:(if different to the above) |
| E-mail Address: |
| Name of Connexions Advisor:(if applicable) |
| E-mail Address: |
| **Is your Local Authority aware of this application?** Yes / No |

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| **Cultural / Spiritual Needs** |
| I have a specific faith and/or belief | Yes / No / Prefer not to disclose |
| If yes, please state which faith group you belong to:  |  |
| I like to attend services in relation to my faith / beliefs:  | Yes / No |
| Please tell us what you may like to attend and how we can support with this: |
| I have special days in the year that I wish to celebrate (please give details): |
| My first language is English: | Yes / No |
| I speak or understand other languages: | Yes / No |
| If yes, please tell us the other languages you speak or understand: |  |

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| **Education** *(only applicable to School or College applications)* |
| I have an Education, Health & Care Plan (EHCP): | Yes / No |
| If no, please provide details of the plan you currently have:  |  |
| Current / Most Recent learning provider: |
| Contact Number:  |
| E-mail Address: |
| Please list the details of learning you have undertaken and any qualifications you are working towards or have achieved (if appropriate): |
| Course | Level | Qualification | Date Completed |
|  |  |  |  |
| If you know, how best do you like to learn? |
| Please provide details of the levels of support you normally have in class / during learning, if any: |
| Please explain why you would like to attend St Elizabeth’s School / College. (Delete as appropriate) |
| What are your hopes and aspirations for the future? |

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| **Emotional Wellbeing** |
| Please use this section to describe your emotional wellbeing (do you have anxiety, depression, self-harm tendencies, vulnerability, shyness?) |
| Are you currently or have you ever been subject to any safeguarding investigations?Yes / No |
| **Counselling** |
| If you have received any counselling or other professional psychological support, please provide us with any information relevant to your application if you wish to do so.  |
| **Medical** |
| GP (General Practitioner) Name: |  |
| Address: | Contact Number: |  |
| E-mail Address: |  |

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| Medical Diagnosis: |
| **Seizure Information (if applicable)** |
| Before a seizure I usually: |
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| After a seizure I usually: |
|  |
| I have seizures at night: **Yes / No** |
| *(If YES please tell us about the frequency and type of seizures):* |
|  |
| Date of last EEG: |  | Result: |  |
| Date of last MRI: |  | Result: |  |
| Other information relevant to seizure management (*e.g. intervention medication, type of seizures and frequency):* |
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| **Medication** |
| Drug Name | Dosage | Time/s Given |
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| **Epilepsy Classification** *(tick all that apply)* |
| Active |  |
| In remission (on medication) |  |
| In remission (off medication) |  |
| Single seizure |  |
| Non-epileptic (associated disorder) |  |
| Partial Epilepsy |  |
| Generalised Epilepsy |  |
| Primary generalised |  |
| Secondary generalised |  |
| Specific Syndrome |  |
| Tonic / Clonic (includes tonic or clonic) |  |
| Absences |  |
| Myoclonic Jerks |  |
| Drop Attacks |  |
| Complex Partial Seizures |  |
| Simple Partial Seizures |  |

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| **Allergies / Drug Sensitivity e.g. foods, pollens, animals** |
| **1.** |
| **2.** |
| **3.** |
| **4.** |
| **5.** |

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| **Mobility** |
| I can walk independently: | **Yes / No** |
| I need help with: |  |
| I use these aids to help me: |  |
| When I go out, I need help with my mobility to (please specify help required e.g. in and out of vehicles, stairs etc.) |  |
| I have fallen in the last 12 months: | **Yes / No** |
| The reason/s I have fallen are: |  |
| Previous fractures: | **Yes / No** |
| If Yes, what was broken and when: |  |
| I have a history of Osteoporosis: | **Yes / No** |

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| **Sensory Assessment** |
| I have difficulties with my vision: | **Yes / No** |
| I wear glasses: | **Yes / No** |
| I have other visual difficulties (please specify): |  |

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| **Hearing** |  |
| I have difficulty with my hearing: | **Yes / No** |
| I use hearing aid/s: | **Yes / No** |
| I have other difficulties with my hearing (please specify): |  |

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| **Mental Health** |
| I have experienced difficulties with my mental health: | **Yes / No** |
| I am under the care of a psychiatrist or psychologist: | **Yes / No** |
| At times I need help with behaviour management: | **Yes / No** |
| If yes to any of the above, please describe help required / input received: |
| **Continence** |
| I generally have normal bladder function: | **Yes / No** |
| I can usually control my bowel movements: | **Yes / No** |
| I wear pads *(please tick relevant box/es)*: | Only during the day Only at night Day and Night Only when I go out  |

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| **Dietary Information** |
| My current weight is: | **…………………….**kg |
| I have special dietary requirements: | **Yes / No** |
| If yes, please specify requirements: |

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| **Immunisations** |
| Are all immunisations up to date?: | **Yes / No** |
| Date of last tetanus injection: |  |

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| **Sleeping** |
| Do you have difficulties settling at night: | **Yes / No** |
| If Yes, please tell us what the difficulties are and what helps them: |
| Do you usually wake during the night: | **Yes / No** |
| If yes, please tell us as much as you can about what wakes you, how often and what we can do to help resettle you: |
| **Therapy** |
| I am currently receiving Physiotherapy: | **Yes / No** |
| If Yes, please tell us what they support you with and how often you access this service: |
| I am currently receiving Occupational Therapy: | **Yes / No** |
| If yes, please tell us what they support you with and how often you access this service: |
| I am currently receiving Speech and Language Therapy: | **Yes / No** |
| If yes, please tell us what they support you with and how often you access this service: |
| Do you have any problems understanding others’ speech? | **Yes / No** |
| If yes, please provide details of what works to support you to understand: |
| How do you express yourself? (Please tick those that apply) | Speech Signing/ non-verbally Communication Aids Other |
| If other, please provide further details: |
| **Additional Information** |
| Please tell us about hobbies and interests you enjoy: |
| Please use this space to tell us anything further you feel is relevant to your application: |

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| **Name and Address / contact details of person completing this form** **(if different from front page)** |  |
| **Relation to applicant:** |  |

Date of form completion:

Thank you for the completion and return of this application. A member of the admissions team will be in contact with you in due course.