Edinburgh Day Service Application Form

Please complete this form and email to: **admissions@garvaldedinburgh.org.uk**
or post to: Admissions, Garvald Edinburgh, 454/1 Gorgie Road, Edinburgh, EH11 2RN
Contact us on: **0131 600 09 09**

Applicant Details

Title: ______________

Name: ____

Date of birth: ______________

What kind of residence do you live in?

☐ Family ☐ Supported accommodation ☐ Live on your own

Address: ____

____

City: ______________________

Postcode: ______________________

Telephone number: ______________________

Mobile number: ______________________

Your email: ____

Attendance

How many days a week do you want to spend with us?

☐ 2 day ☐ 3 days ☐ 4 days ☐ 5 days

Which days do you prefer to spend with us?

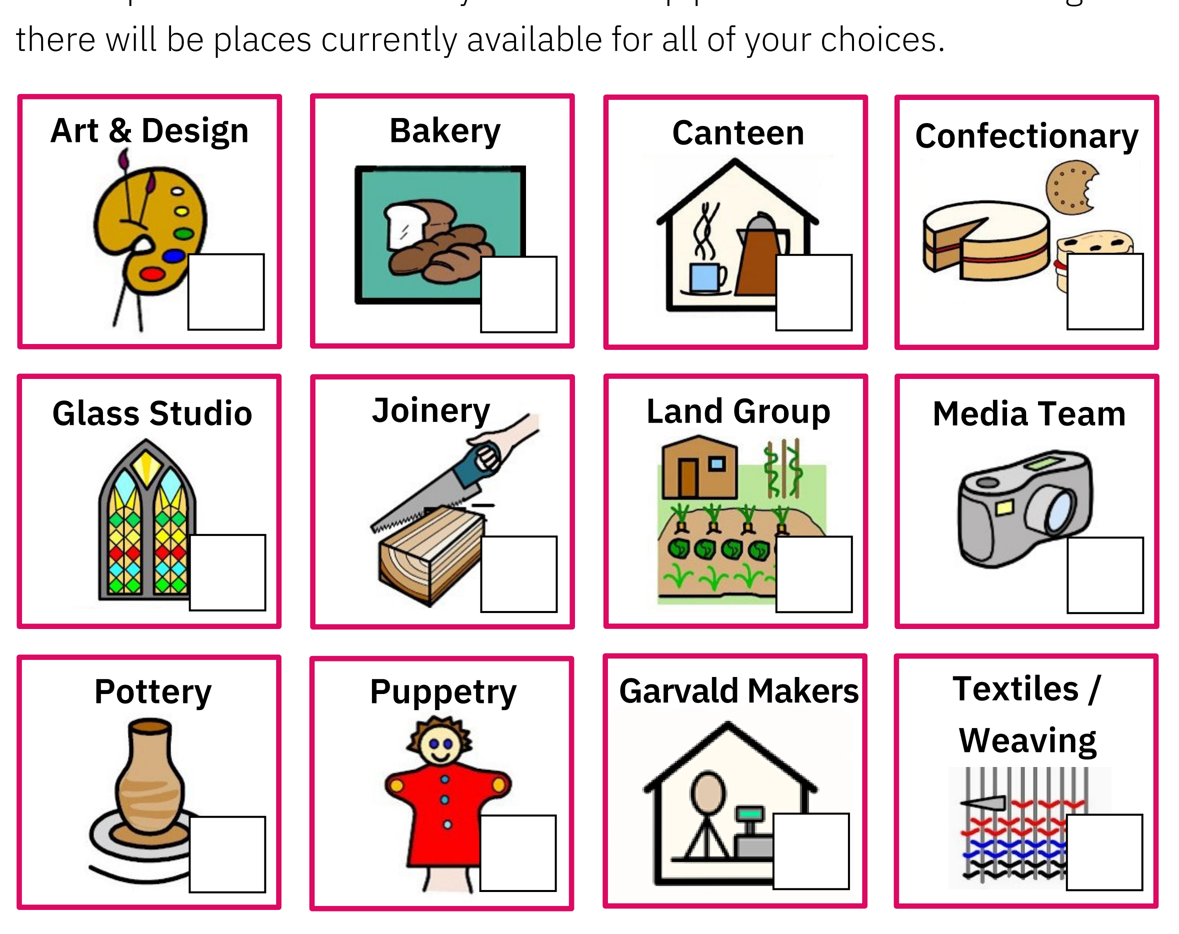
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

If we can offer you a place when would you like to start?

☐ ASAP ☐ Other (*please note preferred start date*)

Workshops Available in the Edinburgh Day Services

Please put an **X** in the box of your workshop preferences. We cannot guarantee that there will be places currently available for all of your choices.



Your Primary Contacts

Who is your **Primary Contact**? This is the person we get in touch with in an **emergency** or if we require additional information.

Name: ____

Relationship to you: ____

Organisation (if applicable): ____

Address: ____

____

City: ______________________

Postcode: ______________________

Mobile number: ______________________

Landline number: ______________________

Work number: ______________________

Email: ____

Who should we contact to discuss your application with?

Your **Primary Contact** Yes ☐ No ☐

Other (*please note below*) Yes ☐ No ☐

Name: ____

Relationship to you: ____

Contact number: ______________________

Email: ____

Is anyone **legally appointed** to make decisions on your behalf? Yes ☐ No ☐

Are they your **Primary Contact**? Yes ☐ No ☐

If No, please provide name and contact details of your legal appointee below:

Name: ____

Relationship to you: ____

Organisation (*if applicable*): ____

Address: ____

____

City: _______________________

Postcode: _______________________

Mobile number: _______________________

Landline number: _______________________

Email: ____

Please select any legal appointments in place below:
(Note: *We will require copies of legal certificates when support starts*)

Power of Attorney Yes ☐ No ☐

Welfare Guardianship Yes ☐ No ☐

Financial Guardianship Yes ☐ No ☐

Has funding been secured for your place at Garvald Edinburgh? Yes ☐ No ☐

Does funding still need to be agreed with the local authority? Yes ☐ No ☐

Do you have a social worker? Yes ☐ No ☐

Supporting You

At Garvald Edinburgh we want you to feel safe, valued and engaged. What support do you need to achieve this?

Please let us know of any emotional support you may need:

Are there particular ways that you communicate your needs that we would need to learn and or may sometimes impact on others?

Please let us know about any support you need with communication:

(e.g. Signalong, Talking Mats)

Please let us know of any support you need in aspects of personal care:

(e.g. using the toilet)

Please describe any help you need with mobility - do you need any special equipment? (e.g. lift, hoist, Closomat toilet)

At Garvald Edinburgh we use a positive behaviour support approach and are experienced in responding to behaviours of concern. Are there any behaviours of concern we should be aware of?

What ratio of staff support do you think you will need to attend Garvald Edinburgh?

Up to 1:8 ☐ Between 1:2 and 1:3 ☐ 1:1 ☐ Don't know ☐

Medical Details

Have you a particular diagnosis? (e.g. Autism, Fragile X)?

Do you have other health conditions?

What medications(s) and dosage(s) do you take?

Would you require medication during our service hours? Yes ☐ No ☐

Please put an **X** in the box that best describes any support you think you need with taking medication:

☐ **Self-managing:** (I don't need any support)

☐ **Prompting** (I only need reminding of when to take medication but can manage to look after it and take the amount prescribed myself)

☐ **Assisting** (I know what medication I need to take but will need assistance opening bottles or pouring out liquids)

☐ **Administration** (I need complete support to store and take medication safely)*

Do you have an up to date *section 47** certificate from the GP? Yes ☐ No ☐

Do you have any allergies to food or medicines? (*please list*) Yes ☐ No ☐

Are there any emergency medical protocols we need to be aware of? (*please note below*) Yes ☐ No ☐

Name of your **doctor(s):** ____

Address: ____

____

City: ______________________

Postcode: ______________________

Contact number: ______________________

Please name any other health care professional involved in protocols we should be aware of? (e.g. occupational therapist, epilepsy nurse, diabetes clinic)

Name: ____

Occupation: ____

Contact number: ____

Name: ____

Occupation: ____

Contact number: ____

Name: ____

Occupation: ____

Contact number: ____

Name: ____

Occupation: ____

Contact number: ____

Your School, College or Work Experience

Please tell us the name of any schools or colleges you have attended and how long you were there:

Date from	Date to	Name of school or college

Please tell us about any work experience either paid or voluntary:

Date from	Date to	Name of employer

What do you do during the day at present?

What are your hobbies / interests?

Your Family / Carers

Family / carer(s): ____

Same as **Primary Contact** Yes ☐ No ☐

Relationship to you: ____

Organisation (if applicable): ____

Address: ____

____

City: ______________________

Postcode: ______________________

Mobile number: ______________________

Landline number: ______________________

Email address: ____

Secondary family / carer(s): ____

Relationship to you: ____

Organisation (if applicable): ____

Address: ____

____

City: ______________________

Postcode: ______________________

Mobile number: ______________________

Landline number: ______________________

Email address: ____

Other Contacts

Your **social worker:** ____

Address: ____

____

City: ______________________

Postcode: ______________________

Landline number: ______________________

Mobile number: ______________________

Email address: ____

Not applicable ☐

Are there any other people, family, friends or professionals whose contact details you would like us to have?

Name: ____

Relationship to you: ____

Organisation (if applicable): ____

Address: ____

____

City: ______________________

Postcode: ______________________

Contact number: ______________________

Email address: ____

Please add any other information that you would like us to know about:

Data Protection and Confidentiality:

The personal information provided on this form will be shared through the application process by managers and staff who will be meeting you. The information will be destroyed if you do not proceed with a placement at Garvald Edinburgh.
If you become a member, the information will be kept in your file in confidence and will only be used according to the aims of our services. It will only be shared appropriately within Garvald Edinburgh or with some outside organisations such as the Health and Social Care Department or other Social Work services, in the circumstances detailed in our Confidentiality policy (available on request from our main office). We will not pass on personal information about you to other people or organisations unless you know and agree to it. We will ask you to let us know when your address or other details change so that we can ensure that the information we hold is accurate and up to date.

Declaration: It is important that you advise us of any previous involvement with the police and / or if you have any history of verbally or physically aggressive behaviour. If this is the case it may not stop you coming to Garvald Edinburgh but it is essential for us to know to enable us to assess whether we can support you safely and ensure the safety of other people attending our day services. **If none please state this, otherwise please put the details below. This detail may need to be discussed further when we meet with you.**

None ☐

Please sign below to show that you understand and agree with the above:

Signature: ____

Date: ____

If completed on behalf of the applicant, please state your relationship to that person:

____

Monitoring Questionnaire

Note: this is gathered for statistical purposes and is not considered as part of your application

Ethnic origin:

In which country were you born? ____

With which of the following categories do you most closely associate yourself, having regard to your ethnic and cultural background?
(*Please put and x in the box / complete)*

BLACK:
- African ☐
- Afro-Caribbean ☐
- UK ☐
- Other (*please specify):* ☐ ________________

WHITE:
- UK ☐
- European ☐
- Other (*please specify):* ☐ _______________________

OTHER:
- Bangladeshi ☐
- Indian ☐
- Pakistani ☐
- Mixed ethnicity ☐ (*please specify):* ______________________________
- Chinese ☐
- Other Asian ☐
- Other ethnicity ☐ (*please specify):* ______________________________