

# CAIRNGORM OUTDOORS LTD

11 The Square  
Grantown on Spey  
PH26 3HG  
01479 870484

## INITIAL REFERRAL INFORMATION

Name of person completing form: .....

Name of young person .....

Date of birth ..... Ethnic/cultural origin.....

Religious observance .....

Legal status .....

Date of next Children's Hearing .....

Date of next LAAC Review .....

Social Worker's name .....

Social Work Office address .....

Contact number/s .....

E mail address .....

Social Worker's Senior .....

Out of Hours contact number and e mail .....

Young person's advocacy worker .....

Contact number .....

## **FAMILY STRUCTURE**

**Person/s with parental responsibility .....**

**Parents' names .....**  
.....

**Parents' home address .....**  
.....

**Parents' contact number/s .....**

**Step parents/partners of parents .....**

**Siblings – name and age .....**  
.....  
.....

**Grand parents/extended family .....**

**Other significant adults .....**  
.....

**Contact arrangements .....**

**Individuals with whom contact is discouraged/not permitted**  
.....  
.....

## **MEDICAL INFORMATION**

**G.P.**

**Name .....**      **Contact number.....**

**Address .....**

**Appointments due** .....

**On going treatment** .....

**Special dietary needs** .....

**Medication** .....

We understand that medical conditions are not seen as preventative to a young person's participation. By informing us of existing conditions prior to any placement, staff can better manage safety and ensure an appropriate activity plan. Failure to specify any existing medical conditions negates Cairngorm Outdoors' higher duty of care with regard to any incident caused by, or causing deterioration to, an existing condition.

**HAS THE YOUNG PERSON HAD ANY OF THE FOLLOWING?**

Respiratory Problems i.e. Asthma or Bronchitis	YES	NO
Heart Condition	YES	NO
Epilepsy i.e. Fits or Fainting	YES	NO
Severe Headaches	YES	NO
Diabetes	YES	NO
Allergies to any known Medication	YES	NO
Any other Allergies	YES	NO
Travel Sickness	YES	NO
Other Illness or Disability	YES	NO
Regular Medication	YES	NO

Please provide details of conditions outlined above or any other condition:

Has the young person suffered from any of the following:

Knee Problems	YES	NO
Back Problems	YES	NO
Other Joint Problems	YES	NO
Heart Disease	YES	NO
High/Low Blood Pressure	YES	NO
Asthma	YES	NO
Epilepsy	YES	NO
Long/Short Sightedness	YES	NO
Dyslexia	YES	NO
Hearing Problems	YES	NO
Recurring Injuries	YES	NO

Is the young person receiving medical treatment of any kind? YES NO

Has the young person received tetanus vaccination in the last 10 years? YES NO

Has the young person been given any specific medical advice to follow in the event of an emergency ?

If the answer to any of the questions above is YES please give details:

## **RISK ASSESSMENT**

Rating Scale 0= no risk 1 = Low risk 2 = Medium risk 3 = Significant risk 4 = High risk  
RISK YES NO RATING

SELF HARM  
Please specify

HARM TO OTHERS/PEERS

THREATS/INTIMIDATION

SUICIDE ATTEMPTS

DRUG/ALCHOL/SOLVENT ABUSE  
Please specify

SEXUALISED BEHAVIOR TOWARDS STAFF AND/OR PEERS

CRIMINAL BEHAVIOUR

ARSON

VICTIMISATION BY OTHERS

ROAD/ VEHICLE SAFETY

MENTAL HEALTH

ALLEGATIONS AGAINST STAFF/OTHERS

PHYSICAL RISK TO STAFF

RISK TO LOCAL COMMUNITY

PROPERTY DAMAGE

ABSCONDING

**AIM OF PLACEMENT .....**

**EXPECTED DURATION .....**

**SIGNATURE .....**

**DATE .....**

