



GARVALD
EDINBURGH

Mayfield House - Midlothian Day Service Application Form

Please complete this form and email to: **mayfieldadmin@garvaldedinburgh.org.uk**
or post back to: Admissions, Garvald Edinburgh, Mayfield House, McSence Business Park,
32 Sycamore Road, Mayfield, Dalkeith, EH22 5TA
Contact us at Mayfield House Reception on: **0131 541 2306**

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? Minimum service is two days.

1 day 2 days 3 days 4 days 5 days

Which days do you prefer to spend with us?





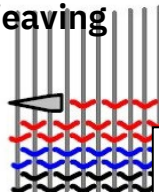
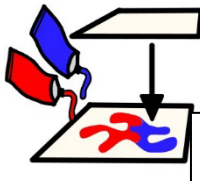
Monday Tuesday Wednesday Thursday Friday

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

ASAP Other (*please note preferred start date*)

Workshops Available in the Mayfield House - Midlothian Day Services

Please put an **X** in the box of your top **3** preferences. We cannot guarantee that there will be places currently available for all of your choices.

<p>Canteen</p>  <input type="checkbox"/>	<p>Jewellery and Design</p>  <input type="checkbox"/>	<p>Land Group</p>  <input type="checkbox"/>
<p>Pottery</p>  <input type="checkbox"/>	<p>Textiles / Weaving</p>  <input type="checkbox"/>	<p>Art and Print</p>  <input type="checkbox"/>

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: _____

Contact number(s): _____

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(s): _____

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.**

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 tick / complete)*

BLACK:	African	<input type="checkbox"/>	WHITE:	UK	<input type="checkbox"/>
	Afro-Caribbean	<input type="checkbox"/>		European	<input type="checkbox"/>
	UK	<input type="checkbox"/>		Other <i>(please specify):</i>	<input type="checkbox"/>
	Other <i>(please specify):</i>	<input type="checkbox"/>		_____	

OTHER:	Bangladeshi	<input type="checkbox"/>			
	Indian	<input type="checkbox"/>			
	Pakistani	<input type="checkbox"/>			
	Mixed ethnicity	<input type="checkbox"/>	<i>(please specify):</i>	_____	
	Chinese	<input type="checkbox"/>			
	Other Asian	<input type="checkbox"/>			
	Other ethnicity	<input type="checkbox"/>	<i>(please specify):</i>	_____	