

**INSIDE RIGHT REFERRAL FORM
YOUNG SERVICE VETERANS WELLBEING FOOTBALL PROGRAMME**

REFERRAL SECTION

A) REFERRERS DETAILS

Name of person making referral

Contact details

Community Team/consultant contact

Date discussed

Participant's health goals

Name and address of GP

B) PARTICIPANT DETAILS

Name

Date of Birth

Address

Telephone number

Home:

Work:

Mobile:

Email

Next of kin or emergency contact

Address

Telephone number

Home:

Work:

Mobile:

Email

Demographics

Age:		Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Race/ethnic group:				
Please tick the box that best describes your racial/ethnic origin:				
A White		C Asian or Asian British		
<input type="checkbox"/> British		<input type="checkbox"/> Indian		
<input type="checkbox"/> Irish		<input type="checkbox"/> Pakistani		
<input type="checkbox"/> Any other White background, please write in: _____		<input type="checkbox"/> Bangladeshi		
		<input type="checkbox"/> Any other Asian background, please write in: _____		
B Mixed		D Black or Black British		
<input type="checkbox"/> White and Black Caribbean		<input type="checkbox"/> Caribbean		
<input type="checkbox"/> White and Black African		<input type="checkbox"/> African		
<input type="checkbox"/> White and Asian		<input type="checkbox"/> Any other Black background, please write in: _____		
<input type="checkbox"/> Any other mixed background, please write in: _____				
		E Chinese or other ethnic group		
		<input type="checkbox"/> Chinese		
		<input type="checkbox"/> Any other, please write in: _____		

C) MEDICAL INFORMATION - To be completed by Participant

Please tick the appropriate box for all of these questions. If you have ticked yes for any question please give details in the right hand column.

If any of the conditions change it is your responsibility to inform either your Link or Everton staff.

Please consult your GP if you are unsure of any of the below

Do you suffer from:

	YES	NO	INFORMATION
Asthma			
Chest Problems			
Epilepsy			
Heart Problems			
Raised or Low Blood Pressure			
Diabetes			

Declarations

- **I agree to receive any basic first aid** **Yes** **No**

Signed: **Link:** **Date:**

Signed: **TEF:** **Date:**

Signed: **Participant:** **Date:**

PARTICIPANT DISCLAIMER

Whilst a member of the INSIDE RIGHT, I agree to fully comply with the following:

- (i) If I am under or suspected of being under the influence of non prescribed and/or illicit drugs or alcohol, I will not be allowed to participate in the activities on offer and will be asked to leave by a member of staff.
- (ii) A risk assessment for any INSIDE RIGHT activity will have been completed prior to the activity commencing. Any significant risk(s) will be discussed with me as appropriate. Consideration will be given to the suitability of the activities chosen to ensure that I am not exposed to any foreseeable and unreasonable risk.
- (iii) I agree to complete a Physical Activity Readiness Questionnaire (PARQ) with project staff prior to commencing the programme and understand that I may be required to seek advice from my GP before undertaking any project activities.
- (iv) Even though I am committed to working with project staff to achieve pre-agreed health goals, I understand that there is no guarantee that my health goals will be reached solely through participation in the INSIDE RIGHT.
- (v) I am not required to take part in every activity and I may opt out of any activity at any time.
- (vi) I will also be expected to take full responsibility for the care of and security of my personal belongings for the duration of the activity.
- (vii) I am responsible for my actions and owe a duty of care to others participating in the INSIDE RIGHT Programme to not intentionally cause injury or loss.

SIGNED.....

PRINT NAME.....

DATE

THIS FORM SHOULD BE SIGNED BY THE PARTICIPANT:

- AFTER A RISK ASSESSMENT HAS BEEN COMPLETED AND ANY RISKS IDENTIFIED HAVE BEEN EXPLAINED TO THE PARTICIPANT.
- BEFORE THE COMMENCEMENT OF ANY INSIDE RIGHT PROGRAMME.