



Please complete as applicable

G.P.:	TEL:
Address:	
CONSULTANT PSYCH:	TEL:
PROBATION OFFICER:	TEL:
CPN:	TEL:
SOCIAL WORKER:	TEL:
KEY WORKER:	TEL:
NEXT OF KIN:	TEL:
RELATIONSHIP:	

MENTAL HEALTH DIAGNOSIS:			
CURRENT MEDICATION:			
DO YOU SELF MEDICATE (Please tick one):			
YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
DO YOU SUFFER FROM ANY OF THESE CONDITIONS: (Please tick any that apply)	ASTHMA:		
	EPILEPSY:		
	DIABETES:		
VISUAL IMPAIRMENT:	<input type="checkbox"/>	HEARING IMPAIRMENT:	<input type="checkbox"/>
MOBILITY DIFFICULTIES:	<input type="checkbox"/>	ANY OTHER PHYSICAL PROBLEMS THAT WE SHOULD BE AWARE OF:	<input type="checkbox"/>
PLEASE SPECIFY THE NATURE OF THE PROBLEM:			
ANY RELIGIOUS / CULTURAL / DIETARY REQUIREMENTS:			

PREVIOUS WORK EXPERIENCE:
HAVE YOU ATTENDED ANY OTHER CENTRES / PROJECTS SIMILAR TO BITA:
CURRENT HOBBIES / INTERESTS:

FOR OFFICE USE ONLY:

DATE RECEIVED:	DATE ACKNOWLEDGED:	BY:
DATE OF FIRST INTERVIEW:	INTERVIEWED BY:	
START DATE:	W/S TEAM:	
HEALTH AUTHORITY	SOCIAL SERVICES	PROBATION
ON DATABASE:	ON REGISTER:	STARTER PACK:
SIGNED OFF BY SUPPORT OFFICE:	DATE:	SIGNED: