# Access to Work: Holistic Assessment Referral Form

## Customer Information

|  |  |
| --- | --- |
| **Customer Name** |  |
| **Does the Customer have an Appointee?****(Yes or No)** |  |
| **If** **yes, enter appointee name, relationship to customer and any other relevant details** |  |
| **URN** |  |
| **NINO** |  |
| **Personal Email** |  |
| **Personal Mobile** |  |
| **Personal Other** |  |
| **Work Email** |  |
| **Work Other** |  |
| **Reasonable adjustment agreed:**(If none leave blank) |  |

## Third Party Information

|  |  |
| --- | --- |
| **Should the third party be contacted instead of the customer to arrange the assessment?** (Please complete when applicable and provide any relevant details  |  |
| **Name**  |  |
| **Organisation (If applicable)** |  |
| **Personal Email** |  |
| **Personal Mobile** |  |
| **Personal Other** |  |
| **Work Email** |  |

## Customer’s availability to arrange assessment.

**The Customer / Third Party is available within the next two working days for contact.**

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|  |

Enter ‘X’ to confirm.

Detail any times the customer is not available to be contacted in the next two working days.

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## Assessment Preference

**Standard Assessment** (use x to indicate)

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| --- | --- |
| **Standard** **Face-to-Face:** |  |
| **Standard** **Virtual:** |  |

**Enhanced Assessment** (use x to indicate)

|  |  |
| --- | --- |
| **TESG:** |  |
| **Supported Internship:** |  |
| **AtW Plus:** |  |

**Customer’s working pattern**

If the customer does not work Monday to Friday standard working hours, please detail their usual working pattern in the box below.

Please advise if the customer can attend an assessment outside of their usual working pattern.

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## Employment Details

|  |  |
| --- | --- |
| **Employer Name:** |  |
| **Employer Contact and Position:** |  |
| **Address:** |  |
| **Telephone / Email:** |  |

## Location of Holistic Assessment if different from above

|  |  |
| --- | --- |
| **Employer Contact and Position:** |  |
| **Address:** |  |
| **Telephone / Email:** |  |

## Any additional ID required by Assessor.

|  |
| --- |
| **Yes / No –** (If yes please specify) |

## Customers Disability and / or Health Condition

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| --- |
|  |

## Customer Job Title / Job Description

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| --- |
|  |

## Customers declared impact on job role.

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## Additional information provided by customer.

e.g., previous experience with special aids and equipment

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## Access to Work Case Manager Information

|  |  |
| --- | --- |
| **Name:** |  |
| **Email address:** |  |
| **Contact Telephone Number:** |  |
| **Working Pattern:**i.e., Mon – Fri 8am to 4pm |  |
| **Date of referral:** |  |