

## Arts on Prescription Referral Form

### For Children and Young People with Long Term Conditions

Please read the information on this page and then, with the person you are referring, complete and return the form on pages 2 to 5.

**Please note** that all sections must be completed as this form is an important data collection and risk assessment tool. Regrettably, we will be unable to process referral forms with incomplete sections.

### Information and Criteria for Referrers

You are able to refer into a choice of three different arts programmes with either Cinderford Artspace, Art Shape or The Music Works. All programmes offer 1:1 or small group to sessions and are bespoke to the young person's likes and wants, based on the principles of "What Matters to Me".

### Please tick your chosen organisation for referral:

Cinderford Artspace

*(Offering circus & aerial skills and pottery)*

Art Shape

*(Offering a range of arts & creative activities including visual arts, animation, photography)*

The Music Works

*(Offering song-writing, learning an instrument, singing, rapping, music tech & computer game soundtracks)*

### Outcomes and targets:

- Increase confidence and emotional resilience
- Increase social connection with other young people with long term health conditions
- Encourage self-management of their health condition through creative activities and whilst taking part in creative and physically active workshops

### Please tick the box below for the condition that applies:

Epilepsy

Respiratory Conditions

Persistent Physical Symptoms (PPS)

Persistent Pain

Type 1 Diabetes

Other

Allergies

Cancer

**Part A - Referred person's details** *(all areas to be completed with person being referred /parent/carer)*

<b>Referred person's name:</b>		<b>NHS number:</b>	
<b>Date of birth:</b>		<b>Gender:</b>	
<b>Name of GP, practice address and contact details:</b>			
<b>Name of parent /carer:</b>		<b>Email address:</b>	
		<b>Phone number:</b>	
<b>Referred person's address:</b>		<b>Postcode:</b>	
<b>Emergency contact details for person referred:</b>	<b>Named person:</b>		
	<b>Relationship to person referred:</b>		
	<b>Contact telephone number:</b>		

**Part A continued - Relevant medical and personal information** *(to be completed by referred person and/or parent/carer)*

<b>Information about your long term health condition</b>	
<p><b>How long have you had your diagnosis?</b></p> <p>Please let us know how confident you are in managing your condition and any other information that would be helpful for us to know to help you enjoy the project safely.</p>	
<p>Please let us know of any other medical needs we need to be aware of or any other information you would like us to know that will help you enjoy this project safely.eg food allergies, other medical conditions etc.</p>	
<p>Please let us know about any other needs including access:</p>	

**Part B - Media consent** *(to be completed by referred person and/or parent/carer)*

Permission for use of photographers and video photography	
We require your permission for any photographs or video photography that we undertake for promotional, educational or merchandising purposes.	
Signing the declaration below gives your consent for you to be photographed or filmed as part of this project.	
I consent to being photographed or filmed for the purposes outlined above	Yes <input type="checkbox"/> No <input type="checkbox"/>
Signed:	
Date:	

**Part C – Referrer’s details** *(to be completed by referrer)*

Referrer’s Name:	
Department/unit/organisation name:	
Position held:	
Referrer’s email:	
Referrer’s contact telephone number:	
Referral Date:	

**Part C – Reasons (s) for referral – please tick all that apply** *(to be completed by referrer)*

- Improve overall well-being  Support management of long term condition
- Creative outlet for difficult feelings  Distraction from health issues
- Improves symptoms of anxiety/depression

**Part D - Consent**

**For Referrers**

*I have assessed this person and to my knowledge the above person meets {providers} referral criteria and there is no medical or other reason why they should not participate in this programme. I understand that*

*{provider} runs non-clinical interventions and does not hold clinical responsibility for the person I am referring. I confirm that I have discussed this referral, and the reasoning for it, with the person I'm referring.*

*I also understand that any data collected about the person will be sent securely to Art Shape, the lead provider of Gloucestershire Creative Health Consortium, before being used in anonymised form to determine the impact of the programme.*

**Signed (referrer signature):** .....Date.....

### For those being referred

*I consent to referral to {provider}. I understand that any personal information shared about me will be treated as confidential in line with Data Protection Act and that it may be securely sent to Art Shape, the lead provider of Gloucestershire Creative Health Consortium, before being used in anonymous form to determine the impact of the programme.*

*I understand that I have the right to (i) withdraw my consent and (ii) access my information. I give permission for my GP (and referrer where different) to be kept informed of my progress and to be contacted if {provider} believes I pose a threat of harming myself or others.*

**Signed :** .....Date.....

### Referral Process:

Referrer liaises with young person/family as appropriate and if they are in agreement, completes this referral form and sends to project co-ordinator:

**For Cinderford Artspace and Art Shape programmes**

**For The Music Works programmes**

Amy Iles [amy.iles1@nhs.net](mailto:amy.iles1@nhs.net)

Michaela Law [Michaela.law1@nhs.net](mailto:Michaela.law1@nhs.net)

Project co-ordinator liaises with referrer and family to let them know of the upcoming programmes and to book their place.

**Thank you for completing this form.**

FOR OFFICE USE ONLY	
Long term condition:	
NHS number:	
Date of receipt:	