**Referral Form – FAMILIES (including pregnancy)**

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| **DATE:** |  |

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| **Complete this form by pressing the either the tab key or the arrow keys to move between fields** |

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| **SUPPORTED PERSONS PERSONAL DETAILS** |
| FULL NAME (Please Print) |  | DATE OF BIRTH: |  | AGE: |  |
| ETHNIC ORIGIN |  | GENDER: |  | RELIGION: |  |
| IS THE PERSON PREGNANT: | **(yes/no)** | DATE BABY IS DUE: |  |
| NUMBER OF DEPENDENTS:(*include imminent births*) |  |
| **DEPENDENTS** |
| **NAME:** | **AGE:** | **D.O.B** | **GENDER:** | **RELATIONSHIP:****(*to supported person*)** |
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|  |  |  |  |  |
| CURRENT ADDRESS |  |
|  |  |
|  |  |
| MOBILE NUMBER |  |
| LEGAL STATUS |  |
| LEAVING CARE ACT STATUS |  |
| NATIONAL INSURANCE No. |  |
| **SUPPORTED PERSONS HEALTH DETAILS** |
| **DOCTOR** |
| **IS THE SUPPORTED PERSON REGISTERED WITH A DOCTOR?** | **(yes/no)** |
| IF YES, PLEASE PROVIDE DOCTOR’S DETAILS |
| DOCTORS NAME |  |
| ADDRESS |  |
|  |  |
|  |  |
| TELEPHONE NUMBER |  |
| **DENTIST** |
| **IS THE SUPPORTED PERSON REGISTERED WITH A DENTIST?** | **(yes/no)** |
| IF YES, PLEASE PROVIDE DENTIST’S DETAILS |
| DENTIST NAME |  |
| ADDRESS |  |
|  |  |
|  |  |
| TELEPHONE NUMBER |  |
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| **OTHER (I.E. REHABILITATION ORGANISATIONS ETC)** |
| NAME OF ORGANISATION |  |
| REASON FOR ATTENDANCE |  |
| CONTACT NAME |  |
| ADDRESS |  |
|  |  |
|  |  |
| TELEPHONE NUMBER |  |
| **RISK ASSESSMENT** |
| **YOU MUST PROVIDE THE LATEST, REVIEWED RISK ASSESSMENT FOR THIS PERSON AND FOR ANYONE WHO WILL BE LIVING/sharing THE SUPPORTED PERSONS PROPERTY, WHERE APPROPRIATE.** |
| **RISK ASSESSMENT ATTACHED** | **Delete as appropriate** | **(yes/no)** |
| \**If not attached please advise why.* |
| **SUPPORTED PERSON PROFILE** |
|  |
| **IS THE SUPPORTED PERSON SUPERVISED UNDER ANY OF THE FOLLOWING?**  | **(yes/no)** |
|  |
| CARE ORDER | **(yes/no)** |
| DETENTION & TRAINING ORDER | **(yes/no)** |
| SUPERVISION ORDER | **(yes/no)** |
| COMMUNITY REHABILITATION ORDER | **(yes/no)** |
| STATEMENT OF SPECIAL EDUCATION | **(yes/no)** |
| ANTI SOCIAL BEHAVIOUR ORDER | **(yes/no)** |
|   |
| **IS THERE ANY HISTORY OF THE FOLLOWING**  | **(yes/no)** |
|  |
| VICTIM OF DOMESTIC ABUSE, BULLYING OR COERCION | **(yes/no)** |
| THEFT | **(yes/no)** |
| VIOLENT BEHAVIOUR | **(yes/no)** |
| ASSAULT (PHYSICAL) | **(yes/no)** |
| ASSAULT (SEXUAL) | **(yes/no)** |
| CHALLENGING BEHAVIOUR | **(yes/no)** |
| SELF HARMING | **(yes/no)** |
| DRUG ABUSE | **(yes/no)** |
| SUBSTANCE MISUSE | **(yes/no)** |
| ALCOHOL ABUSE | **(yes/no)** |
| ARSON | **(yes/no)** |

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| **OTHER PROBLEMS/ISSUES (PLEASE FULLY DESCRIBE BELOW)** | **(yes/no)** |
| If the answer is yes to any of the questions in this section please provide full details here: |
| **SUPPORTED PERSON DAYTIME ACTIVITIES** |
|  |
| **DOES THE SUPPORTED PERSON ENGAGE CURRENTLY IN EDUCATION/TRAINING?** | **(yes/no)** |
| PLEASE PROVIDE FULL DETAILS |
| **DOES THE SUPPORTED PERSON ENGAGE CURRENTLY IN WORK?** | **(yes/no)** |
| PLEASE PROVIDE FULL DETAILS |

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| **HAS THE SUPPORTED PERSON ANY PARTICULAR INTEREST WHICH COULD BE EXPLORED?** |
| PLEASE PROVIDE FULL DETAILS |
| **SUPPORTED PERSON SUPPORT NETWORKS** |
|  |
| **DOES THE SUPPORTED PERSON HAVE/WISH FOR ANY CONTACT WITH FAMILY/SIGNIFICANT PERSON?** | **(yes/no)** |
| PLEASE PROVIDE FULL DETAILS |
| **APART FROM BEDSPACE STAFF, WILL THERE BE ANY OTHER SUPPORT FROM ELSEWHERE (I.E OTHER AGENCIES/ORGANISATIONS)?** | **(yes/no)** |
| PLEASE PROVIDE FULL DETAILS |

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| **SUPPORTED PERSON ACCOMMODATION** |
|  |
| **WHAT AREA(S) WOULD THE SUPPORTED PERSON PREFER TO LIVE?** |
|  |
| **NUMBER OF BEDROOMS REQUIRED:** |  |
| **NUMBER OF PEOPLE EXPECTED TO LIVE IN THE PROPERTY:** |  |
| **DOES THE SUPPORTED PERSON HAVE ANY EXPERIENCE OF LIVING INDEPENDENTLY / SEMI INDEPENDENTLY?** |
| PLEASE PROVIDE FULL DETAILS |

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| **REASON FOR REFERRAL** |
| PLEASE PROVIDE DETAILS OF THE SUPPORTED PERSONS CURRENT SITUATION, INCLUDING THE REASON FOR THE SUPPORTED PERSON LEAVING THEIR CURRENT ADDRESS (INCLUDE A BRIEF FAMILY HISTORY/BACKBROUND, CARE HISTORY AND ANY OTHER INFORMATION WHICH MAY BE RELEVANT TO THE REFERRAL). |
| **ASSESSMENT OF SUPPORTED PERSONS SUPPORT NEEDS** |
| **BRIEF SOCIAL WORK / PERSONAL ADVISOR ASSESSMENT**  |
| IN ADDITION TO THE INFORMATION GIVEN WITHIN THIS REFERRAL, PLEASE LIST ANY OTHER AREAS OF CONCERN, INDEPENDENCE NEEDS AND ANY RECOMMENDATIONS TO ASSIST THE SUPPORTED PERSON IN LIVING WITHIN THE COMMUNITY. |
|  |
| **HAS THE SUPPORTED PERSON AGREED AND CONSENTED TO THIS REFERRAL?** | **(yes/no)** |
| Signature of Referrer……………………………………………. |

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| --- |
| **REFERRER** |
|  |
| **REFERRER DETAILS** |
| REFERING AGENCY |  |
| NAME OF REFERRER |  |
|  ADDRESS |  |
|  |  |
| TELEPHONE NUMBER |  |
| EMAIL ADDRESS |  |
| NATURE OF REFERRER RELATIONSHIP WITH SUPPORTED PERSON |  |
| DATE OF REFERRAL |  |
| **AUTHORITY ORDER NUMBER** |  |
| PROPOSED PLACEMENT START DATE |  |
| AUTHORISED PLACEMENT SIGNATURE | ……………………………………………………… |
| **WHERE DID YOU HEAR ABOUT BEDSPACE?** |
| *(From a* *previous referral, colleague, Service User, meeting/forum, web search, literature, etc.*) |