**Referral Form SINGLE PERSON**

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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** | |  | | |
| **CURRENT ADDRESS** | |  | | | | | | | | | | |
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|  | |  | | | | | | | | | | |
| **MOBILE NUMBER** | |  | | | | | | | | | | |
| **LEGAL STATUS** | |  | | | | | | | | | | |
| **LEAVING CARE ACT STATUS** | | | |  | | | | | | | | |
| **NATIONAL INSURANCE No.** | | | |  | | | | | | | | |
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| **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** | | |  | | | | | | | | | |
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| **TELEPHONE NUMBER** | | |  | | | | | | | | | |
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| **DENTIST** | | | | | | | | | | | | |
| **IS THE SUPPORTED PERSON REGISTERED WITH A DENTIST?** | | | | | | | | **(yes/no)** | | | | |
| **IF YES, PLEASE PROVIDE DENTIST’S DETAILS** | | | | | | | | | | | | |
| **DENTIST NAME** | | |  | | | | | | | | | |
| **ADDRESS** | | |  | | | | | | | | | |
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| **TELEPHONE NUMBER** | | |  | | | | | | | | | |
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| **OTHER (I.E. REHABILITATION ORGANISATIONS ETC)** | | | | | | | | | | | | |
| **NAME OF ORGANISATION** | | |  | | | | | | | | | |
| **REASON FOR ATTENDANCE** | | |  | | | | | | | | | |
| **CONTACT NAME** | | |  | | | | | | | | | |
| **ADDRESS** | | |  | | | | | | | | | |
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| **TELEPHONE NUMBER** | | |  | | | | | | | | | |

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| **RISK ASSESSMENT** | | | |
| **YOU MUST PROVIDE THE LATEST, REVIEWED RISK ASSESSMENT FOR THIS PERSON.** | | | |
| **RISK ASSESSMENT ATTACHED** | **Delete as appropriate** | **(yes/no)** | |
| **\**If not attached please advise why.*** | | | |
| **SUPPORTED PERSON PROFILE** | | | |
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| **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)** |
| **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** | | | |
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| **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** | | | |
| **HAS THE SUPPORTED PERSON ANY PARTICULAR INTEREST WHICH COULD BE EXPLORED?** | | | |
| **PLEASE PROVIDE FULL DETAILS** | | | |

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| **SUPPORTED PERSON SUPPORT NETWORKS** | |
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| **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** | |
| **SUPPORTED PERSON ACCOMMODATION** | |
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| **WHAT AREA(S) WOULD THE SUPPORTED PERSON PREFER TO LIVE?** | |
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| **DOES THE SUPPORTED PERSON HAVE ANY EXPERIENCE OF LIVING INDEPENDENTLY / SEMI INDEPENDENTLY?** |
| **PLEASE PROVIDE FULL DETAILS** |
| **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).** |

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| **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.** | |
| **Recommended number of support hours REQUIRED?** |  |
| **HAS THE SUPPORTED PERSON AGREED AND CONSENTED TO THIS REFERRAL?** | **(yes/no)** |
| **Signature of Referrer…………………………………………….** | |

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| **REFERRER** | | |
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| **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** | | **………………………………………………………** |
| **BILLING ADDRESS, NAMED CONTACT & TELEPHONE NUMBER:** | | |
| **WHERE DID YOU HEAR ABOUT BEDSPACE?** | | |
| ***(From a* *previous referral, colleague, Service User, meeting/forum, web search, literature, etc.*)** | | |