**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** |  |
|  |  |
|  |  |
| **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** |  |
|  |
| **OTHER (I.E. REHABILITATION ORGANISATIONS ETC)** |
| **NAME OF ORGANISATION** |  |
| **REASON FOR ATTENDANCE** |  |
| **CONTACT NAME** |  |
| **ADDRESS** |  |
|  |  |
|  |  |
| **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** |
|  |
| **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** |
|  |
| **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** |
|  |
| **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** |
|  |
| **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.*)** |