**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 | |  | | | | | | | | | | | | | | | | | | |
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| 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 | | | | |  | | | | | | | | | | | | | | | |
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| TELEPHONE NUMBER | | | | |  | | | | | | | | | | | | | | | |
| **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 |  | | | |
|  |  | | | |
|  |  | | | |
| 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.*) | | |