# Referral and Assessment Form

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| **SECTION ONE – to be completed by referrer** | | | | |
| **Customer details** | | | | |
| **Customer Name** |  | | | |
| **Address** |  | | | |
| **Is English their first language?** |  | | | |
| **Telephone** |  | | **E-mail** |  |
| **Sex** | Male  Female  Transgender  Other | | **NI Number** |  |
| **Date of Birth** |  | | **Age** |  |
| **Are there any dependants or non-dependants living at the home?** |  | | **If yes, please provide their names, dates of birth and relationship** |  |
| **Next of Kin or person to contact in an emergency** |  | | **Relationship to You** |  |
| **Telephone** |  | | **Email** |  |
| **Referral Source** | | | | |
| **Referring Agency** |  | | **Name** |  |
| **Telephone** |  | | **Email** |  |
| **Does the applicant have recourse to public funds?** | | | Yes No | |
| **REASON FOR REFERRAL**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **INITIAL RISK CHECKLIST** | | | | | | **Please provide any risk history you are aware of and if so, please detail what the risk is and how this is managed. If you have your own risk assessment, you may send this too.** | | | | | | **Risk Assessment History** | **Tick** |  | | **Tick** | | Mental Health concerns |  | Sex offences | |  | | Non-compliance with medication |  | History of violence | |  | | Planned or attempted suicide |  | About to leave or recently left prison | |  | | Self-harm |  | Environmental risks | |  | | Hoarding |  | Use of dangerous weapons | |  | | Self-neglect |  | Arson | |  | | Learning disability |  | Domestic abuse | |  | | Safeguarding concerns |  | About to leave hospital | |  | | Physical disability |  | Recently left hospital | |  | | Addiction; drug / alcohol /Gambling |  | Pets | |  | | Incidents involving the police |  | Risk from others if known | |  | | **RISK MANAGEMENT** | | | | | | Briefly describe the risks identified | | | | | |  | | | | | | Are there any risks that are not currently being managed? If so please state below | | | Yes  No | | | |  | | --- | | If the referral has come from a partner agency you agree that verbal consent has been provided prior to this referral being sent. Any information gathered will be treated in the strictest confidence in accordance with the Data Protection Act 2018  **Name:**  **Date:** | | | | | | | | | | |
| **SECTION TWO – to be completed by One Support** | | | | |
| Support case ID: |  | Database ID: | |  |
| Name of your housing provider |  | Type of housing and length of time at property | |  |
| Do you own a property or have a tenancy at another property? | | | | Yes  No |
| Do you have any outstanding rent arrears?  If yes, how much? | | | | Yes  No |
| Do you have any outstanding Council Tax arrears?  If yes, how much? | | | | Yes  No |
| Have you ever been served with a legal notice by your landlord? | | | | Yes  No |
| Have you ever lost accommodation because of violence, harassment, drug taking or any other breach of a tenancy or licence agreement? | | | | Yes  No |
| **Employment status** | | | | |
| Full time work  Part time work  Government Training / Work programme  Job seeker  Retired  Not seeking work  Full time student  Carer  Unable to work – sickness/ disability  Other | | | | |
| **Are you in receipt of?** | | | | |
| Job Seekers Allowance  Income Support  ESA  Carers Allowance  PIP / Disability Living Allowance  Attendance Allowance  Pension Credit / Pension  Tax Credits  Universal credit  Other benefits | | | | |
| **Are you ex-armed forces personnel?** | | | | Yes  No |

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| **Agencies known to applicant** | | | |
| **GP Name / Surgery:** | | | |
| Telephone: | | |  |
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| **CMHT:** | | | |
| Telephone: | | |  |
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| **Adult Social Care:** | | | |
| Telephone |  | | |
| Email |  | | |
| **Probation service / Officer:** | | | |
| Telephone |  | | |
| Email |  | | |
| **Drug or Alcohol service:** | | | |
| Telephone |  | | |
| Email |  | | |
| **Other** (please specify) | | | |
| Address | |  | |
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| **Your support needs** |
| Prevention e.g. eviction and section 21 notices |
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| **Your support needs** |
| Intervention e.g. debt issues |
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| **Your support needs** |
| Engaging with other services e.g. referring to outside agencies |
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**This additional sheet is to help gather additional information that may not be contained in the assessment that may be relevant for the support planning. This may be used also to describe any observation during the assessment**.

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| **Would you like any information regarding the following:** |
| Volunteering  Attending a forum  Taking part in a service inspection  Any service events |

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| **Equal opportunities monitoring** | | | | | | | |
| One Support is committed to promoting equal opportunities in all aspects of its service. The information requested in this form will help us monitor the effectiveness of our policies and will be treated in the strictest confidence. | | | | | | | |
| **Are you** | | Male  Female  Transgender  Other: | | | | | |
| **What is your nationality?** | |  | | | | | |
| **How old are you?** | | | | | | | |
| 16 - 17  18 - 24 | 25 - 40  41 - 59 | | | 60 - 64  Over 65 | | | Do not wish to disclose |
| **How would you describe your ethnicity?** | | | | | | | |
| White British  Irish Other white background, please specify Black or Black British Caribbean  African Other Black background, please specify **Asian or Asian British**  Indian  Pakistani  Bangladeshi  Other Asian background, please specify Mixed White and Asian  White and Black Caribbean White and Black African  Other mixed background, please specifyOther Ethnic Group Arab  Chinese  Traveller - Gypsy / Romany Irish  Other, please specify | | | | | | | |
| **How would you describe your religion, belief?** | | | | | | | |
| None  Buddhist  Christian | | | Hindu  Jewish  Muslim | | | Sikh  Any other religion  Do not wish to disclose | |
| **Do you consider yourself to have a disability?** | | | | | No  Yes, please specify below | | |
| Hearing impairment  Learning Disability  Mental Health | | | Mobility  Progressive disability  Chronic illness | | | Visual impairment  Other  Please specify | |
| **How would you describe your sexual orientation?** | | | | | | | |
| Heterosexual  Bisexual | | | Homosexual  Do not wish to disclose | | | Other  Please specify: | |
| **ADDITIONAL COMMENTS FROM CUSTOMER** | | | | | | | |
| Is there any additional information you want to tell us about? | | | | | | | |
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| **Outcome of Assessment** | | | | | | | | |
| **Support Officer Name** | | | |  | | | |
| **Signature** | | | |  | | | |
| **Date** | | | |  | | | |
| **Team Manager** | | | |  | | | |
| **Signature** | | | |  | | | |
| **Date** | | | |  | | | |
| **Team Manager Decision** | | | | Accept  Reject | | | |
| If rejected, please give reasons: | | | | | | | |