# 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**

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| **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  |
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| Are there any risks that are not currently being managed? If so please state below  | Yes [ ]  No [ ]  |
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| 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:**       |

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| **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 specify      Other 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:   |