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**The Hollies, 83 Birch Lane, Dukinfield, Greater Manchester, SK16 4AJ.**

**Referral Form for Supported Accommodation**

**This form is to be completed to refer applicants who suffer from mental health issue by the appropriate professional person who is making this referral for example the service users Doctor, CPN, Social Worker, Care Coordinator, etc. Additionally, we also welcome completed forms from individuals or family members or carers on their behalf. When completed this form please can you give as much information as possible, this will help us process the application quicker. Please attach most recent care plans, risk assessments, MDT notes and nursing needs assessment.**

**Referral Criteria**

We have no fixed criteria for qualification for our services. Each Resident’s needs are assessed and if they have a requirement falling within our range of expertise, we

will endeavour to meet those requirements, in agreement with other social care professionals and their family.

Payment for our services can come from social services departments, primary care trusts, charities, the Independent Living Fund, CCGs, funded nursing care or privately.

The funding authority is then sent a written proposal outlining the agreed care package and fee. Once an individual has been accepted, and funding has been agreed, the Resident is provided with a moving in date.

**PLEASE READ CAREFULLY**

**All sections of this form must be completed. Failure to do so may cause delays. If for any reason a section cannot be filled out, please state why. Blank sections will not be accepted. If there is no space for your answer, please use the extra sheet provided at the end of this form, thank you.**

**Section 1 – Referral Agency Details**

|  |  |
| --- | --- |
| Referral Agency and contact details and email address) |  |
| Referral Agency Phone Number |  |
| How long have you known the applicant |  |
| Reason for referral |  |
| Date of Referral |  |

**Section 2 – Applicant Details**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Applicant | |  | | | Contact No | | |  |
| Current Address | |  | | | | | | |
| Previous extended hospital admissions or supported accommodation placements. | | | | | | | | |
| Interpreter Required: | | Yes / No: | | | Language: | | |  |
| Age | Date of Birth | | National Insurance Number | | | Mobility issues  Yes / No / Don’t Know | | |
|  |  | |  | | |  | | |
| Gender: | | | | Religion: | | | Sexuality: | |

**Applicant Details- Continued**

|  |  |
| --- | --- |
| Does the applicant have income including benefits? Yes / No  Name Benefits: | If no, please provide details of the action you have taken e.g. referral to Debt Adviser. |
| GP Name, Address and Contact Number |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Ethnic origin as defined by applicant** | | | White British | |  | White Irish |  | White & Black Caribbean |  |
| White & Black African |  | White / Asian |  | Indian |  | Pakistani |  | Bangladeshi |  |
| Caribbean |  | African |  | Chinese |  | Refused |  | Other |  |

**Section 2 – Family and professional Support Network**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** | **Forename** | **Relationship** | **Any safeguarding / child protection concerns?** |
|  |  |  | Adult: -  Child (if any children – record details & contact): - |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Section 3 – Diagnosis, Current Accommodation Situation and Mental Health Care Package**

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| --- |
| **Current Accommodation Situation and why does there need to be a change / why can current accommodation not meet needs? Please include any Section 117 notes** |
| **Describe current mental health care package.** |

|  |  |
| --- | --- |
| **Diagnosis**  **(please provide all physical and mental health)** | 1)  2)  3)  4)  5)  6)  7) |

**Section 4 – Complete If the Applicant Is Currently an Inpatient.**

|  |  |  |  |
| --- | --- | --- | --- |
| Is Applicant currently sectioned under the MHA? | Yes / No | If yes, Which section? |  |
| Current Leave status |  | | |

**Section 5 – Support Group/Needs**

|  |  |  |
| --- | --- | --- |
| **Support Group** | **Yes/No** | **support Needs:** Please provide details of level and type of support required |
| Mental health problems |  |  |
| Single Homeless with support needs |  |  |
| Training, Education, Employment |  |  |
| Primary Health Care, Mental Health or Drug/Alcohol Services |  |  |
| Accommodation / Housing |  |  |
| Safeguarding: Avoiding self-harm and/or causing harm to others/avoiding harm by others |  |  |
| Independent Living Skills |  |  |
| Inclusion in community |  |  |
| Social Isolation / Contact with family / friends |  |  |
| Other (Please specify) |  |  |
| Other concerns |  |  |

**Section 6 – Risk Assessment**

|  |  |
| --- | --- |
| **Risk Assessment – please ensure accurate and detailed.** | |
| **Harm to Self** | **Harm to Others** |
| **Self-Neglect/ Neglect of others** | **Vulnerability** |
| **Alcohol / illicit Substance Use** | **Convictions / forensic history** i/c any pending criminal justice issues |
| **Damage to property and Arson** | **Antisocial Behaviour** |
| **Current Risk Management** | |

|  |
| --- |
|  |

**Section 6 – Any Other Relevant Information**

**Section 7- Applicant’s Declaration/Authorisation**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Please tick Yes or No if you agree to the following:*** | | | **Yes** | **No** |
| **The information I have given is accurate to the best of my knowledge** | | |  |  |
| **I give my consent to the disclosure of this information to Next Steps** | | |  |  |
| **I give my permission for the outcome of this referral to be explained to the referral agency** | | |  |  |
| **I would like a copy of this referral form** | | |  |  |
| **I agree to this information being emailed to Next Steps VIA secure email.**  If no then the form will be faxed or posted. If the form is emailed, then a signed copy will be posted to the service(s) at a later date for audit purposes | | |  |  |
| **Applicant’s Signature:** |  | | | |
| **Print Name:** |  | **Date:** | | |

**Section 8- Referring Agent Declaration**

**I confirm the information I have given, is to the best of my knowledge, true and accurate and that all known risks have been detailed in order for a full risk assessment to be carried out (duty of candour)**

**Signature: Designation: Date:**