Transitions – Semi –independent living (UK Ltd)

REFERRAL FORM

Date of referral:

Referrers details:

Referrer's name:

Details of involvement with applicant:

Organisation:

Address:

Contact Tel no

Email address

Applicants details:

First Name: Surname

Date of birth: Age:

Ethnicity:

GP: GP Address:

Present address:

Type of current accommodation (e.g. family home, foster placement, hostel, secure accommodation etc)

Length of time at current address:

Contact No's:

LDD/Disability needs:

Reasons for making a referral to this organisation?

Care/support plan already in place Yes No Please Attach

What would the referrer and applicant agree are the main areas of support needed whilst living at one of our homes

What would the applicant like to achieve from living at one of our homes

Please indicate expected duration of placement (between 6 months to 2 years)

Housing history:

Please give a detailed housing history including any periods of homelessness

Has the young person ever been evicted? Yes/No

Has a Housing Application form been completed? Yes/No

Risk assessment.

Please tick as appropriate

Arson	High	Medium	Low	N/A
Physical aggression to others	High	Medium	Low	N/A
Verbal aggression	High	Medium	Low	N/A
Damage to property	High	Medium	Low	N/A
Alcohol Abuse	High	Medium	low	N/A
Drug/Substance Misuse	High	Medium	Low	N/A
Sexual Behaviour (risk to others	High	Medium	Low	N/A
Self Harm	High	Medium	Low	N/A
Criminal behaviour	High	Medium	Low	N/A
Sleep disturbance/nocturnal difficulties	High	Medium	Low	N/A
Mental Health i.e ongoing historical or significant emotional health issues	High	Medium	Low	N/A

Please indicate any other risk factors and complete on separate paper if necessary

Care & support required (tick as appropriate)

Does he/she require assistance with any of the following areas? Please indicate the assistance required **H-** high, **M-** medium, **L** – low, **N-** none

Assistance required	**H**	**M**	**L**	**N**	**Assistance Required**	**H**	**M**	**L**	**N**
Budgeting					Behaviour /anger management				
Paying bills					Registering with GP				
Accessing benefits					Physical health care problems				
Domestic life style					Nutrition/ weight				
Personal hygiene					Family mediation				
Health & safety in the home					Peer mediation				
Escorting					Vulnerable exploitation				
Accessing social & recreational activities					mobility				
Language or literacy					Religious/cultural				
Access to education & employment					Medication/prescription				

Please indicate if there is other assistance required

1.

2.

3.

Contact details of other agencies involved in the clients care or supervision

Name & Address of Agency	Name of contact & telephone number

Any information given relating to racial or ethnic origin, physical or mental health and criminal convictions constitutes sensitive data as defined by section 2 of the Data Protection Act 1998. I consent to the information given by me, including such information as constitutes sensitive data, being used, in accordance with the principles of the Data Protection Act 1998, for the purpose of processing my application and if successful in gaining a placement, for delivering services to me.

The above information is accurate and true to the best of my knowledge:

Signature of applicant: **Date:**

Signature of referrer: **Date:**

Please send completed referral form together with any relevant reports or assessments to:

Transitions Living
13a, Golders Green Road, London N11 8DY