REFERRAL / RISK ASSESSMENT

PLEASE COMPLETE ALL INFORMATION AVAILABLE TO YOU

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| **Date of Assessment** |  | **Name of Assessor** |  |
| **Preferred Residing Area** |  | **Telephone number** |  |
| **Organization** |  |
| **PERSONAL DETAILS OF APPLICANT** |
| Preferred Title: | Mr. |  | Miss |  | Mrs. |  | Ms. |  | Other |  |
| Surname: |  | First Name (s): |  |
| Other Name (s) Known as |  | Date of Birth: |  | Place of Birth: |  |
| Address: (where have you been living/stayingpreviously) including Postcode |  |
| Home No: |  | Mobile Tel No: |  |
| Work No: |  | National Insurance No: |  |
| Gender |  |  | Marital Status: |  |
| Current Situation/Reason for Homelessness: |  |

**DIVERSITY MONITORING FORM** |
| **ETHNIC ORIGIN** |
| White: British |  | White: Irish |  | White: Other |  | Mixed: White & Black Caribbean |  |
| Asian/Asian British: Indian |  | Mixed: White & Asian |  | Mixed: Other |  | Mixed: White & Black African |  |
| Asian/Asian British:Pakistani |  | Asian/Asian British: Bangladeshi |  | Asian/Asian British: Other |  | Black/Black British: Caribbean |  |
| Black/Black British: African |  | Black/Black British: Other |  | Chinese/Other Ethnic Group |  | Refuse to say |  |
| If you have listed other: Specify |  |
| **RELIGION** |
| No religion/Atheist |  | Muslim |  | Christian  |  | Sikh |  |
| Buddhist |  | Hindu |  | Jewish |  | Prefer not to say |  |
| Any other: Please Specify |  |
| **SEXUAL ORIENTATION** |
| Heterosexual |  | Homosexual |  | Lesbian |  | Transgender |  |
| Bisexual |  | Other: |  | Prefer not to say |  |  |

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| **COMMUNICATION NEEDS** |
| Are any of the following needed? |
| Large Print |  | Braille |  | Audiotape/CD |  | Translation/ Interpreter\* |  |
| Pictures & Symbols |  | Easy Read |  | BSL/Makaton |  | Other\* |  |
| If yes, please provide more details: |  |

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| **PHYSICAL AND MENTAL INFORMATION** |
| Do you have any physical health conditions? (If yes please give details) |
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|  Do these health conditions influence your daily living? (If yes please give details) |
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|  Do you have any Mental Health conditions?  (If so, please give details of condition and if you have any support from Mental Health services. |
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| Are you prescribed medication? If so, what are you prescribed and what is it for? |
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| If so, do you need reminding to take your medication? YES NO |
| Do you need help to manage/improve your Mental Health? YES NO |
| Are you registered with a GP? (If yes please provide details) |
| Do you need help to register with Healthcare Services? YES NO |
| Doctors | Opticians | Dentist |
| **SUBSTANCE USE** |
| Do you use drugs and alcohol?  |  YES |  NO |
| What drugs do you use? And how often. | What alcohol to you use? And how often. |
| Do you have a Drug/Alcohol worker? (If so, please give details. Company, worker, contact details, any prescription information) |
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| **ADDITIONAL SUPPORT AND CONTACT** |
| Please give details if you receive regular support from any of the listed agencies: |
| Social Worker |  | CPN |  |
| Probation Officer |  | Psychiatrist/Psychologist |  |
| Please provide Name, Address & Contact Telephone numbers: |
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| **FINANCIAL INFORMATION** |
| Please specify source(s) of income: |
| What is your source of income: What benefits are you on? (Tick as appropriate) |
| UNIVERSAL CREDIT ESA PIP |
| Total AmountReceived: |  | How Often | Daily | Weekly | Monthly | Other |
| Do you have any outstanding FINES OR ARREARS? |
| Are you repaying your outstanding fines or arrears?  |
| Does anybody owe you any money? Do you require assistance to recoup this money?  |
| Do you have a Bank Account? If no, would you like assistance in opening an account? |
| **CRIMINAL RECORD** |
| Have you ever been convicted of a criminal offence or have any pending court appearances? If yes, please give details below: | YES: | NO: |
| Propensity to Re-Offend % Year 1……….. Year 2……… |  |  |
| Nature of Offence | Date | Sentence |
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| Are you subject to any orders? DRR/Probation/Injunctions, if applicable please give details of probation officer. |  | Date orders end: |
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PLEASE NOTE: the declaration of criminal offences(s) does not necessarily mean that you will be excluded from being offered a housing related support package

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| **Support Needs** |
| Reason for requiring Supported Housing(**Please tick at least 5 in order to be considered for supported accommodation)** |
| Access to local services Rough Sleeping |  | Becoming homeless / evicted (within 28 Days) |  |
| Improved quality of life |  | Ability to manage ongoing health problems |  |
| Skills to eat healthily |  | Access to health services |  |
| Access voluntary services |  | Build an alternative support network |  |
| Ability to manage personal hygiene |  | Risk of domestic abuse |  |
| Increase social and community networks |  | Frequent presentation to accident and emergency |  |
| Unplanned hospital admissions |  | Reduce social isolation |  |
| Accessing drug and alcohol services |  | Obtaining or maintaining a suitable home |  |
| Getting involved in activities |  | Increased feelings of being less reliant |  |
| Gaining and / or maintaining employment and /or education and training |  | Risk of long-term worklessness |  |
| Deteriorating financial position |  | Developing household skills |  |
| Help to find other help |  | Feeling more involved |  |
| Risk of offending |  | Risk of harm from others |  |
| Risk of self-harm |  | Reducing feelings of isolation |  |
| Ongoing health issues |  | Ability to be keep home safe & secure |  |
| Developing problem solving skills |  | Ability to manage a healthy lifestyle |  |
| Developing personal competence |  | Developing self esteem |  |
| Increased feelings of being more independent |  | Ability to manage health & wellbeing |  |
| Ability to manage £ better |  | Developing people skills |  |
| Increased knowledge |  | Increased confidence |  |
|  Do you have contact with your family? | Yes | No |
|  If YES, what support do they provide if any? Are there any other people that help you? |
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| **NEXT OF KIN DETAILS** |
| **Name: Contact Number Relationship:** |
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| **RISK ASSESSMENT** |
| Risk Indicators – This information is required to allow support workers to prepare for the assessment fully. Please give as much detail as you are aware of especially where there may be concerns for lone working. Please note, if this information is left blank or there is lack of information, it may result in a delay of the referral being processed.\*If you are making this referral for an individual that is not known to you and/or you do not consider it appropriate to complete this section, please tick here □ (Please ensure the ‘Network of Support/other agencies involved’ details are completed in full as this will allow us to make the necessary enquiries regardingrisk. |
| Potential Risk Area | LOW | MED | HIGH | Potential Risk Area | LOW | MED | HIGH |
| Violence or Aggression |  |  |  | Harm to self, others orfrom others |  |  |  |
| Known associates |  |  |  | Criminal/police or court involvement (present/previous) |  |  |  |
| Substanceabuse/alcohol misuse |  |  |  | Mental Health |  |  |  |
| Attempted suicide |  |  |  | Sex Offences |  |  |  |
| Self-Harm |  |  |  | Domestic Abuse |  |  |  |
| Arson |  |  |  | Extreme anger & hostility |  |  |  |
| Property damage |  |  |  | Other (please specify) |  |  |  |
|  Violent ideas/acts |  |  |  |  |  |  |  |
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| **DECLARATIONS** |
| I agree that the information contained in this referral form is true and accurate. I consent to it being used as part of the assessment and risk process. By signing below, I agree that all the information provided is true and I will inform the provider of any changes. I also understand that R4H have the right to refuse support if I have provided and information that is incorrect/false. |
| INFORMATION SHARING: I understand that R4H will carry out checks on the information I have provided through contact with other agencies’, e.g., Medical Professionals, Probation Services, social services etc. I am signing to say I give permission to share information about me with other agencies |
| Full Name: Date:Signature: |
| Office Use OnlyReferral Accepted: Yes or No (delete no applicable) Reason referral was not acceptedDate:  |

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