REFERRAL FORM

FOR SUPPORTED LIVING

This form should be completed by a qualified professional making the referral, such as the service user's doctor, CPN, social worker, or care coordinator.

We also welcome referrals submitted by individuals, family members, or carers on their behalf.

Please provide as much detailed information as possible when completing this form, as it will assist us in processing the application more efficiently.

Please attach previous care plans and risk assessments

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| SECTION 1 – CONTACT DETAILS |
| 1. REFERRING AGENT |
| Team: |  |
| Contact Name: |  | Tel Number: |  |
| Team Location: |  |
| 2. SERVICE USER DETAILS |
| Surname: |  | Title: |  |
| First Name(s): |  |
| Current Address with Post Code: |  |
| Contact Number: |  |
| 3. DOCTOR’S DETAILS |
| Name of GP: |  | Tel Number: |  |
| Address of Surgery: |  |
|  |
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| SECTION 2 - SUPPORT |
| Are you requesting MEDICSPROCARE to provide supported accommodation for this individual? This means that the individual needs regular ongoing housing related support from us as a landlord, that is over and above that needed in an unsupported tenancy and separate to any other support or care arrangements |
| Yes / No | If the answer to this question is No, then our service is possibly not appropriate, and you should seek housing from 'General Landlords' |
| If Yes: Briefly outline the housing related supported that the individual will need to enable them to manage their tenancy successfully: |
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| Are you requesting this accommodation because no other alternative accommodation is available? Yes / NoBriefly explain the reasons why the tenant is not able to be provided with accommodation by Local Authority, Housing Association or Private Landlord: |
|  |
| Would the tenant be classed as a “vulnerable person” | Yes / No |
| In what way is the tenant vulnerable? |
| Is the tenant in receipt of / or qualifies for DLA or incapacity benefits? | Yes / No |
| If DLA please state what rate for Care and what Rate for Mobility:£ perStart date of benefit payments:Are they waiting to hear about any benefits: When did they claim: |
| Medical Condition (Diagnosis, symptoms, etc): |
|  |
| Legal Status if any (e.g. section 25, 117, forensic, or other): |
|  |
| Other Relevant Agencies involved in care: |
| *Please provide name and contact details:* |
| Brief Social History (events that led to intervention, homelessness) |
|  |
| Please provide Client Support Needs with Accommodation (e.g. home economics,Appointeeship, maintenance of tenancy, etc) |
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| SECTION 3 - HOUSING |
| Property Specifications: |
| Date accommodation needed by:(This must be a date between 14 and 90 days of this referral date) |
| Please inform us of current accommodation and notice required and reasons whythey are leaving: |
|  |
| What Type of property do you need? Details of each room, as applicable (Including minimum numbers required, size of rooms, equipment, adaptations, etc): |
| Bedroom (s) |  |
| Living Room |  |
| Kitchen |  |
| Bathroom |  |
| External – garden, parkingetc |  |
| Special Requirements / adaptations to property due to specific disability |  |
| Local area (please detail what the service user’s needs are and anything they would not want. We should think about what we want to achieve in the way of future outcomes and how we might want this person to access their community inthe future): |
| *For example location, transport, amenities, community:* |
| SECTION 4 –RISK ASSESSMENT |
| Risk to self: |
|  |
| Risk to others (staff, neighbours, children, other tenants): |
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| Risk to property: |
|  |
| Has there ever been evidence of arson? If yes please provide details: |
|  |
| Please provide any other recorded events of significance relating to tenancy/properties: |
|  |
| Additional Information (include here any drug or alcohol dependency or abuse that will have an effect on a tenancy – other known individuals that associate with the Client that may have an effect on the tenant): |
|  |
| Criminal Convictions, ASBO or Injunctions: |
|  |
| SECTION 5 – RISK MANAGEMENT OF A PROPERTY |
| Looking at the risk statements below and based on your knowledge of the individual please can you tick which statement best describes the individual’s risks at parts 1 and 2. Only tick one of the 5 statements for the fire risk and one of the 5 statements for damage to property. |
| 1. Fire risk assessment: |
| RiskRating | Risk Statement | 🗸 |
| 1 | There is no historical or present information of any risk of causing a fire, not a smoker or misuse of alcohol or drugs. |  |
| 2 | There is no historical or present information of any risk of causing a fire, Service user is deemed to be a responsible smoker. |  |
| 3 | There is no historical or present information of any risk of causing a fire; client is a smoker and abuses alcohol or drugs or will allow other to visit the property who may smoke and abuse alcohol or drugs. |  |
| 4 | There is historical or present evidence of causing fire damage or fire risk but no conviction. |  |
| 5 | There is historical or present evidence of causing fire damage or fire risk and has been convicted of arson. |  |
| SECTION 6 – MISSING PERSONS |
| Height |  |
| Hair Length/ Colour |  |
| Eye Colour |  |
| Body Build |  |
| Distinguishing body features  |  |

**SIGNATORY**

**Please complete the details below**

Name of person completing this form:

Designation:

Contact number:

Email address:

Organization:

Signature:

Date:

Please return this form to info@medicsprocare.com or MEDICSPROCARE

4 Claremont Avenue, New Malden, KT3 6QL, London, UK

Please call 0208 9420117 if you have any queries on how to complete this form