**REFERRAL / RISK ASSESSMENT**

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| Date of Assessment  |  | **Name of person undertaking Assessment**  |  |
| Preferred 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/staying previously) |  |
|  | Postcode: |  |
| Home No: |  | Mobile Tel No: |  |
| Work No: |  | National Insurance No: |  |
| Gender | Male | Female | 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 (all denominations) |  | Sikh |  |
| Buddhist |  | Hindu |  | Jewish |  | Prefer not to say |  |
| Any other: Please Specify |  |
| **SEXUAL ORIENTATION**  |
| Heterosexual |  | Homosexual |  | Lesbian |  | Trans Gender |  |
| Bisexual |  | Other: |  | Prefer not to say |  |  |
| **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: |  |
| **MEDICAL INFORMATION**  |
| Please give details of any disabilities and / or illnesses that you may have: |
|  |
| **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: |
|  |  |
| **FINANCIAL INFORMATION** |
| Please specify source(s) of income: |
| What is your source of income: What benefits are you on? |  |
| Total Amount Received: |  | How Often | Daily | Weekly | Monthly | Other |
| **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: |
| Nature of Offence | Date | Sentence  |
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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)** |
| Tenancy failure or losing short term accommodation |  | Becoming homeless / evicted (within 28 Days) |  |
| Ongoing issues with drug and alcohol |  | Ability to manage ongoing health problems |  |
| Access to local services Rough Sleeping |  | Access to health services |  |
| Improved quality of life |  | Build an alternative support networks |  |
| Skills to eat healthily  |  | Access voluntary services |  |
| 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 interpersonal skills  |  |
| Increased knowledge |  | Increased confidence |  |

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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 regarding risk. |
| Potential Risk Area | Yes | No | Potential Risk Area | Yes | No |
| Violence or Aggression  |  |  | Harm to self, others or from others |  |  |
| Known associates  |  |  | Criminal/police or court involvement (present/previous) |  |  |
| Hazards from Others (friend/family/visitors) |  |  | Substance abuse/alcohol misuse |  |  |
| Recent discontinuation of medication |  |  | Mental Health |  |  |
| Attempted suicide |  |  | Sex Offences  |  |  |
| Arson |  |  | Domestic Abuse  |  |  |
| Violent ideas/acts |  |  | Extreme anger and hostility |  |  |
|  |  |  | Other (please specify) |  |  |
| Details: |
|  |
| **DECLARATIONS** |
| I agree that the information contained in this referral form is true and accurate and 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 ASH-SHAHADA have the right to refuse support if I have provided and information that is incorrect/false.  |
|  | Signature |
| INFORMATION SHARING: I understand that ASH-SHAHADA 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 |  |
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**PLEASE RETURN FORM TO** referral@saifsocialcare.com

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| **Office Use Only**Referral accepted □ Yes □ NoReason referral was not accepted\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |