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| **47 CAUSEYSIDE STREET, PAISLEY PA1 1YN****Telephone: 0141 849 1229** **Email:** referrals@youfirstadvocacy.org |
| **CRITERIA:-** Please tick place an **X** in the appropriate box below. |
| Mental Health |  | Learning Disabilities |  |
| Older Person 60+ |  | Physical Disabilities |  |
| **CLIENT DETAILS:** |
| Name:  | Male **⁯** Female **⁯** |
| DOB: |  |
| Address: | Mob No:Tel No: |
| Postcode: | NI Number: |
| Email:  |
| **GP/CONSULTANT**Full Name:Address:Telephone Number:Email: Details of medical/health diagnosis: |
| **REFERRER -** Please tick place an **X** beside appropriate referrer.Social Work (Area Teams) Support Services (Care) Crises Service Nurse/Hospital MHO CPN Relative/Carer Care Home Housing RAH Dykebar Legal Services Community Mental Health GP’s Physiotherapist Addiction Services Integrated Alcohol Team Elderly Mental Health Services Self **(If Self please indicate if this was via any other Service/Professional)**  |
| Name and Designation:Address:Telephone Number:Email: |
| **REASON FOR REFERRAL:** |  |
| Is The Person Aware and in Agreement to Referral? Yes □No □ |
| Does the person have a preference for their advocate?Male □Female □None □ |
| **EMERGENCY CONTACT PERSON:**  | Name: Relationship to Client:Address: Post Code:Telephone No: Email: |
| **RISK ASSESSMENT**If there is any information re risk that our agency needs to be aware of please fill in details below:-1. Is there a current/recent risk of attempted suicide or self-harm?2. Is there a history or currently, a risk of violence or aggressive behaviour?3. Are there Court Cases currently or pending related to risk factors? 4. Is there a history or currently, an issue of drug/alcohol dependence?Details/further information regarding risk that our agency needs to be aware of? |
| **Risk Assessment Completed by:** | Name:Designation:Address:Telephone Number:Email: |
| **OTHER AGENCIES INVOLVED:** | Name:Designation:Address:Telephone Number:Email: |
| Name:Designation:Address:Telephone Number:Email: |
| **ISSUE:** | Please tick place an **X** beside appropriateBenefits ⁯ Adult Support & Protection - Investigations ⁯ Complaints ⁯ Adult Support & Protection - Conferences ⁯ Emergency Detention ⁯ Community Care (Assess/Review) ⁯ Serious Abuse Issues ⁯ Child Protection – Investigations ⁯ Child Protection - Conferences ⁯ Hospital Care and treatments ⁯ Financial Crises ⁯ Housing ⁯ Mental Health ⁯ Guardianship ⁯ Debt ⁯ Employment Anti-social Behaviour Self Directed Support ⁯ Homelessness ⁯ General **(Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)** |
| **DATE:** |  |
| **OFFICE USE ONLY:** | Referral taken by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Tick one: New Referral □** **Re-Referral □** **One off □**Date Allocated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Advocate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Closed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Complete outcome and make a copy for outcome folder) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

Return Completed Referrals to: referrals@youfirstadvocacy.org