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| **47 CAUSEYSIDE STREET, PAISLEY PA1 1YN**  **Telephone: 0141 849 1229**  **Email:** [referrals@youfirstadvocacy.org](mailto: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 appropriate  Benefits ⁯ 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](mailto:referrals@youfirstadvocacy.org)