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| **. +****47 CAUSEYSIDE STREET, PAISLEY PA1 1YN****Telephone: 0141 849 1229** **Email:** referrals@youfirstadvocacy.org**Standard Referral Form** |
| **CRITERIA:** Please place an **X** in the appropriate box below. |
| Mental Health |  | Learning Disabilities |  |
| Older Person 60+ |  | Physical Disabilities |  |
| Parent Carer |  |  |
| **SERVICE USER DETAILS:** |
| Name:  | Male 🞏 Female 🞏 |
| DOB:  |  |
| Address:  | Tel No:Mob No:  |
| Postcode:  | NI Number: |
| Email:  |
| **GP/CONSULTANT: (if relevant)**Full Name: Address: Tel No:Email: Details of medical/health diagnosis: |
| **REFERRER:** Please place an **X** beside appropriate referrer type**Social Work (Area Teams)** 🞏 **Support Services (Care)** 🞏 **Crisis Service** 🞏 **Nurse/Hospital** 🞏 **MHO** 🞏 **CPN** 🞏 **Relative/Carer** 🞏 **Care Home** 🞏 **Housing** 🞏 **RAH** 🞏 **Dykebar** 🞏 **Legal Services** 🞏 **GP** 🞏 **Alcohol and Drug Recovery Services (ADRS)** 🞏 **Physiotherapist** 🞏 **Community Links Worker** 🞏**Community Mental Health Team (CMHT)** 🞏  **Older People’s Mental Health Services (OPCMHT)** 🞏**Self** 🞏 **If Self specify if this was via any other Service/Professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Other** 🞏 **Please specify**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **REFERRER NAME AND DESIGNATION: (if not self-referral):**Address:Tel No:Mob No: 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:**  | Name: Relationship to Service User:Address: Post Code:Tel 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-harm2. 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 and Designation: Address: Tel No: Mob No: Email: |
| **OTHER AGENCIES INVOLVED:** | Name and Designation:Address:Tel No:Mob No:Email: |
| Name and Designation:Address:Tel No:Email: |
| **ISSUE:** | Please place an **X** beside appropriate**Benefits** 🞏 **Complaints** 🞏 **Debt** 🞏 **Housing** 🞏 **Financial Crisis** 🞏 **Homelessness** 🞏**ASP-Conference** 🞏 **ASP- Investigation** 🞏 **Community Care (Assess/Review)** 🞏 **Serious Abuse Issues** 🞏 **Employment** 🞏 **Hospital Care and Treatments** 🞏**Child Protection – Investigations** 🞏 **Child Protection – Conferences** 🞏**Parental Support** 🞏 **Guardianship** 🞏 **Mental Health Issues (General)** 🞏 **Anti-Social Behaviour** 🞏 **Hospital Care and Treatments** 🞏**Self-Directed Support (SDS)** 🞏 **General** 🞏 **(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ )** |
| **OFFICE USE** |
| Date Received:  | Referral taken by: |
| **New Referral** 🞏  | **Re-Referral** 🞏  |
| Date Allocated: | Advocate: |
| Date Closed: (Complete outcome and make a copy for outcome folder) |

Return Completed Referrals to: referrals@youfirstadvocacy.org