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