ADULT SOCIAL CARE REFERRAL FORM

REFERRAL DATE: [dd/mm/yyyy]	

DETAILS OF THE PERSON REQUIRING ASSESSMENT/SUPPORT:

TITLE:	FORENAME(S):	SURNAME:

PREFERRED NAME:	GENDER:
DATE OF BIRTH:	AGE:
MARITAL STATUS:	DOES THE PERSON LIVE ALONE? Yes ☐ No ☐
ETHNICITY: Select Ethnicity	PREFERRED LANGUAGE:
ADDRESS:	COMMUNICATION NEEDS:
	IS AN INTERPRETER REQUIRED? Yes ☐ No ☐
	IF YES WHICH LANGUAGE?
CONTACT DETAILS -	NATIONAL INSURANCE NUMBER:
HOME PHONE:	NHS NUMBER:
MOBILE:	HAVE YOU EVER SERVED IN THE ARMED FORCES? Yes ☐ No ☐
EMAIL:	

GP DETAILS:

GP NAME:		GP ADDRESS:
GP PHONE NUMBER:		

DETAILS OF PERSON MAKING REFERRAL:

NAME:	RELATIONSHIP TO CLIENT:
TELEPHONE NUMBER:	
EMAIL:	

RELEVANT REPRESENTATIVE DETAILS:

TITLE	FORENAME(S):	SURNAME:
RELATIONSHIP:		
ADDRESS:	CONTACT DETAILS	
	HOME PHONE:	
	MOBILE:	
	EMAIL:	
	PREFERRED METHOD OF CONTACT:	
DETAILS OF ANY PERSON/S WITH LEGAL/FINANCIAL AUTHORITY: (Lasting Power of Attorney for Property & Finances and/or Health and Welfare/Court Appointed Deputy/Appointee)		

CONSENT:

You should always check that the person agrees to the referral before sending any information. A referral can only be made without consent when there is risk of harm occurring or the person lacks the mental capacity to give their consent.

IS THE CLIENT AWARE OF THE REFERRAL?	Yes	☐	No	☐
HAS THE CLIENT GIVEN THEIR INFORMED CONSENT FOR THE REFERRAL?	Yes	☐	No	☐
IF CONSENT HAS NOT BEEN OBTAINED, PLEASE STATE REASON:				

CARERS' ASSESSMENTS:

If your request is for a carer's assessment only, please complete the questions below. For all other requests please disregard this carers' assessments section and continue with the rest of the form.

NAME OF CARED FOR PERSON:	DATE OF BIRTH & AGE OF CARED FOR PERSON:
ADDRESS OF CARED FOR PERSON:	REASON REQUIRES SUPPORT/CARE:
PROFESSIONAL INVOLVEMENT: *Please provide details of any known professionals involved and contact details e.g. District Nurses, Consultant etc.*	

SUMMARY OF REASON FOR REFERRAL CONTINUED:

Please answer the following questions:

PLEASE PROVIDE DETAILS OF THE CLIENT'S DISABILITY OR MENTAL HEALTH CONDITIONS:
PLEASE STATE HOW THE DISABILITY OR MENTAL HEALTH CONDITION AFFECTS THEIR ABILITY TO COMPLETE ANY DAILY TASKS:
PLEASE PROVIDE DETAILS OF ANY SPECIFIC RISKS TO THE PERSON'S WELL-BEING IN CONNECTION TO THEIR NEEDS/ DIFFICULTIES:
PLEASE PROVIDE DETAILS OF ANY CURRENT UNPAID/INFORMAL SUPPORT IN PLACE (REGARDLESS OF WHETHER THIS IS GOING TO CONTINUE):

SUMMARY OF REASON FOR REFERRAL:

Please provide specific details relating to the person's disability and their needs for care and support, including which service is being requested.

ADVOCACY CHECKLIST: Is the client likely to have substantial difficulty taking part in the assessment process due to any of the following?		
Difficulties understanding the relevant information?	Yes ☐	No ☐
Using the relevant information to make decisions about their needs for care and support?	Yes ☐	No ☐
Retaining the relevant information for as long as is necessary to enable them to make decisions about their needs for care and support?	Yes ☐	No ☐
Communicating their views/wishes/decisions in relation to their needs for care and support?	Yes ☐	No ☐
Does the client have someone of their choice available who is willing and able to support them to take part in the assessment process?	Yes ☐	No ☐
(If the answer is 'NO' a referral will be made for an Independent Advocate to support the client)		
PLEASE RETURN COMPLETED REFERRAL TO SECURE EMAIL: FirstContactAdults@stockton.gov.uk		

For office use only:
FIRST CONTACT STAFF DETAILS:

NAME:	
ROLE:	