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| **Person Details** | | | | | |
| **Name:** |  | | **Gender:** | **Male**  **Female** | |
| **Tel No:** |  | | **Age:**  **D.O.B:** |  | |
| **Address:** |  | | | | |
| **Organisation Referred from:** |  | | | | |
| **Reason for Referral: eg poor mental health, anxiety, depression. Please be as explicit as possible** |  | | | | |
| **Any other organisations involved (please provide, name of organisation; name of contact; position; tel no etc. if known)** | |  | | | |
| **G P Surgery – Name & Contact details** | |  | | | |
| **RISK INFORMATION** | | | | |

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| Has the person ever been known to be aggressive or violent?  If “YES”, please give full details: YES NO |
| Does the person’s behaviour present a risk to themselves  or others? If “YES”, please give full details and frequency: YES NO |
| Do you know of any alcohol and/or substance  (recreational or prescribed) misuse? If “YES”, please give full details:  YES NO |
| Is the person at risk from illness? If “YES”, please give full details:  YES NO |
| Is the person at risk of self-neglect, self-harm or suicide?  If “YES”, please give full details and dates of last incident. YES NO |
| Is the person vulnerable to exploitation by others? (include provision of financial advice, handling their money, physical abuse, sexual abuse, emotional abuse or neglect)  If “YES”, please give full details: YES NO |
| Are there any other risks to the person, staff members or others? (include other household members, family members, friends or pets) If “YES”, please give full details:  YES NO |
| Does this individual have a Care Plan in place? If so is there any information on the Care Plan that HUTS need to be made aware of?  If “YES”, please give full details:  YES NO |

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| **If referred by a GP / Social Worker / Hospital / Other Agency, please complete the below:** |
| I am making this referral with the clients full knowledge and consent and have completed the above information to the best of my knowledge\*  I may be contacted if insufficient information has been provided or clarity is required.  Signed: ..………………………………………………………………. Date: ….............................................  Name (CAPITAL LETTERS:)………………………………………..…………………………….……………..………  Organisation: …………………………………..………………………………………………………………………….  Telephone No: ………………………………..…………………………………………………………………………...  Email Address: ……………………………………………………………………..……………………………………..  Please return this form to: HUTS Workshop. Teifi Terrace, Adpar, Newcastle Emlyn. Ceredigion. SA38 9ED  Tel: 01239 710377 |

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| Date received |  |

\*Once we have received the completed referral form we will make contact with the referred person using the ‘phone number you have provided. Please ensure the person is aware of this.