

HUMBERCARE ACCOMMODATION SCHEME

REFERRAL FORM

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Grimsby
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Statement of Purpose

Humbercare – an enabling organisation dedicated to providing quality and innovative services to adults and young people in need

PROJECT BRIEF

The Humbercare Accommodation Scheme will provide short, long and emergency term placements. The young persons will be supported by accommodation providers in the North East Lincolnshire area. The support will focus on the assessment of individual needs of each young person and delivering improved outcomes.

- We provide a person centred service.
- A rights based enabling approach to the promotion of independence.
- We support young people to develop the living skills necessary to move on to independent living.

Young People are encouraged to access training and education, to increase skills and access to employment

Support can include tenancy or resettlement advice, support with money management or debt issues, claiming benefits and support to deal with other professionals, e.g. health and housing.

Please complete all the sections of the form fully. Failure to do so will delay the assessment process. If you require assistance in completing this form, contact the duty officer on:

THIS INFORMATION IS REQUIRED IN ORDER TO ENABLE HUMBERCARE TO MAKE A RISK ASSESSMENT ON THE APPROPRIATENESS OF THE PLACEMENT WITHIN THE PROJECT

SURNAME		FORENAME(S)	
D.O.B:		GENDER:	
N.I. NUMBER:		ETHNIC ORIGIN:	
ADDRESS		TEL: MOBILE:	
FOSTER/RESIDENTIAL CARE <input type="checkbox"/>	LODGING WITH FRIEND/FAMILY <input type="checkbox"/>	HOSTEL <input type="checkbox"/>	If hostel – has the move on protocol been implemented YES/NO
REFERRED BY		FULL POSTAL ADDRESS	
		POST CODE	
TEL:	FAX:	EMAIL ADDRESS:	
WOULD YOU BE HAPPY FOR CORRESPONDENCE TO BE SENT VIA EMAIL?			YES/NO
WOULD YOU BE WILLING TO ATTEND A JOINT INTRODUCTORY VISIT?			YES/NO
HAS SUPPORT BEEN RECEIVED FROM HUMBERCARE BEFORE?			YES/NO
DO YOU REQUIRE COPIES OF CORRESPONDENCE WE SEND TO YP?			YES/NO
DATE REFERRED:			

RELEVANT ISSUES			
OFFENDING - CURRENT	SUBSTANCE MISUSE (please specify below) *	OTHER MEDICAL PROBLEMS	
OFFENDING - PREVIOUS	METHADONE PROGRAMME	BUDGETING ISSUES	
VIOLENCE/ AGGRESSION	ALCOHOL	FINANCE/DEBTS	
ARSON OFFENCE	FORTHCOMING REHAB PLACEMENT (please provide date below)	INTERPERSONAL SKILLS	
SEX OFFENDER	LEARNING DISABILITY	DAILY LIVING SKILLS	
MENTAL HEALTH	PHYSICAL DISABILITY	OTHER (please specify below) *	
SUICIDAL TENDENCIES	BEEN IN CARE		
ABUSED	SELF HARM		
Other *			

Are there any cultural or faith requirements? Does the application need to be processed in a different language/assistance from an interpreter?

Are there any hearing or visual requirements? e.g. hearing loop or large print text required?

Medication

Details	How often taken

Current/most recent offences

RISK TO SELF (explain below) **LOW** **MEDIUM** **HIGH**

RISK TO STAFF (explain below) **LOW** **MEDIUM** **HIGH**

Past convictions for Arson, Sex Offences or Offences against Children (If yes, provide full information below) YES/NO

Please provide all relevant information regarding relevant, support needs, risk, previous convictions, mental health issues, including any high risk situations or triggers that will assist us to make a risk assessment.

OTHER AGENCIES INVOLVED

NAME	AGENCY	CONTACT NO
GP/Dentist	ADDRESS	CONTACT NO
NEXT OF KIN	ADDRESS	CONTACT NO

INCOME

TYPE OF BENEFIT	AMOUNT	DEDUCTION	HOW OFTEN

ANY OTHER INFORMATION INCLUDING 6 WEEK MOVE ON PLAN FOR CIN REFERRALS & YOUNG PERSON'S LIFE CHRONOLOGY

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NEEDS AND RISK ASSESSMENT

Name of Young Person	
GENERIC <input type="checkbox"/> COMPLEX NEEDS <input type="checkbox"/> (Please Tick)	
<u>BEHAVIOUR</u> <i>(i.e verbal, physical aggression, pushing boundaries, etc, inappropriate sexual behaviour, known triggers that initiate behaviour and how managed, times, people, situations)</i>	
<u>SELF CARE</u> <i>(i.e. hygiene, toileting, meal times, dressing/undressing, bed times etc, / help needed i.e. verbal / physical prompts encouragement to complete tasks)</i>	
<u>MOBILITY</u> <i>(How you feel the young person will handle physical activities i.e. Road Safety – are there are any risks?)</i>	
<u>MEDICATION / MEDICAL HISTORY</u> <i>(Known medication and frequency of medication / Known medical conditions i.e. epilepsy, mental health, asthma, incontinence)</i>	
<u>SOCIAL SKILLS</u> <i>(Ability to build relationships, known aggressive behaviour, dependency on staff, communication difficulties, coping with noise and large groups)</i>	

COMMUNICATION

Does the young person have problems with communication?

YES / NO

(If yes, please give details)

RISKS TO SELF/OTHERS

(Please give details)

ROUTINES

Does the young person have any set routines that we should be aware of?

(i.e. medication, obsessive rituals, meal/bed times, contact with significant people)

EDUCATION / TRAINING AND EMPLOYMENT

EMOTIONAL AND BEHAVIOURAL DEVELOPMENT

General:

Risk To / From:

Offending:

FAMILY AND SOCIAL RELATIONSHIPS

CARE HISTORY

Provider	Dates Placed:
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Contact Arrangements (if applicable)

What is the Pathway Plan?

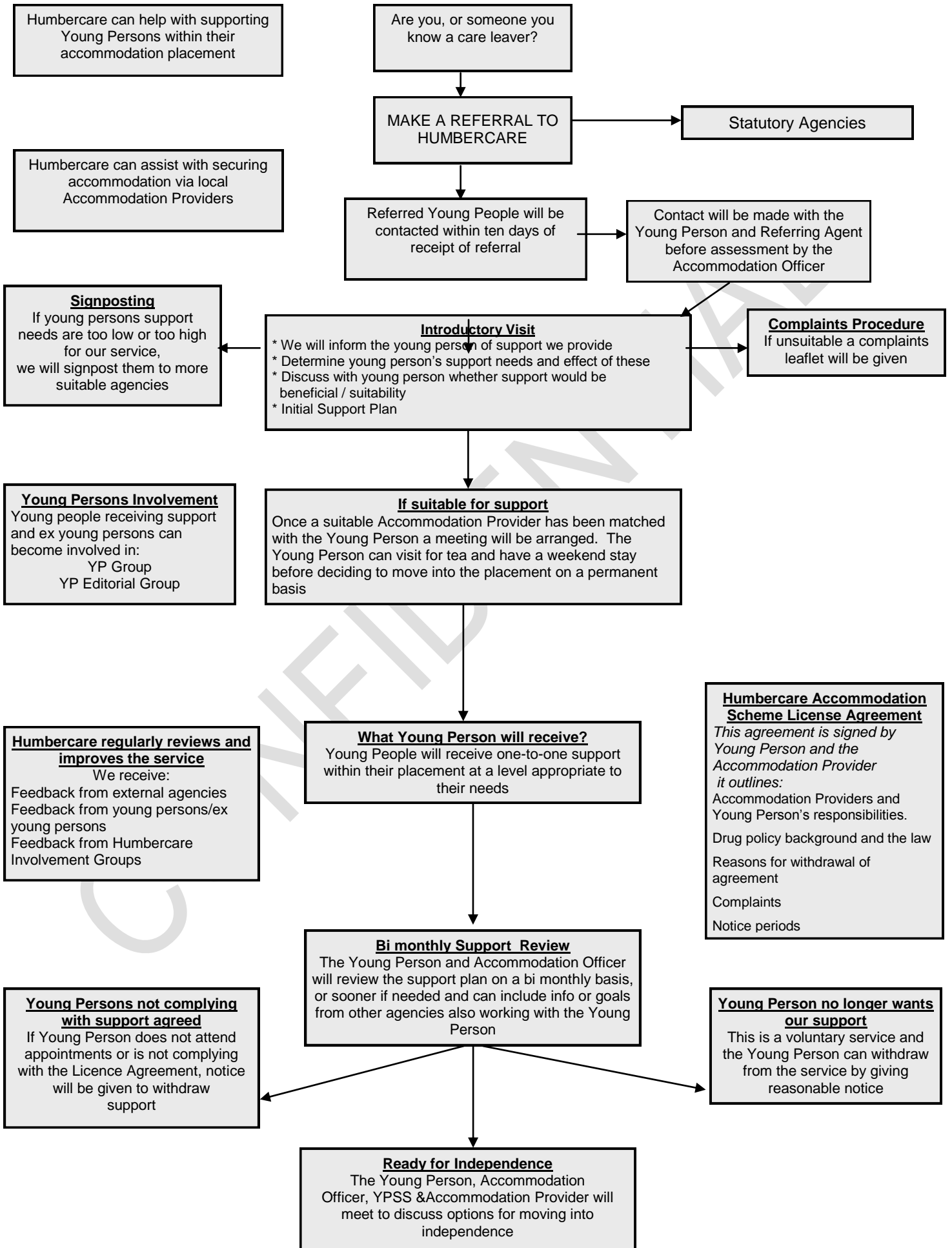
Additional Information:

Signed:	Date:
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Relationship to young person
(i.e parent/guardian/personal advisor)

Organisation <i>(if applicable)</i>	
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REFERRAL PATHWAY



PLEASE EMAIL / POST REFERRAL TO ADDRESS AT FRONT OF FORM

CONSENT TO DISCLOSE INFORMATION

Under the Data Protection Act 1998, you are required to give your consent for this information to be passed to Humbercare. Personal information will not be disclosed without your consent except to perform statutory duties. By signing this form you are giving permission for Humbercare to share and receive information with agencies that you have made reference to within this form, this will enable us to gain additional information required to further assess your support needs.

I have read the above form and I am happy that the information given is shared with others in order to assist me with my support needs.

What are your wishes and feelings about your referral to Humbercare?

YOUNG PERSONS SIGNATURE:

YOUNG PERSONS NAME:

DATE:

WITHOUT SIGNED CONSENT,
WE ARE UNABLE TO PROCEED
WITH YOUR REFERRAL

CONFIDENTIAL