

REFERRAL INFORMATION

Complete & Fax To 0151 922 0991

SOCIAL WORKER:	TELEPHONE/FAX:
ADDRESS:	
EMERGENCY DUTY TEAM:	TELEPHONE/FAX:
SENIOR MANAGER:	TELEPHONE/FAX:

SERVICE USER PERSONAL INFORMATION

NAME:	AGE:
ALIAS:	D.O.B.:
N.I. NUMBER :	NHS NUMBER:
GENDER:	ETHNIC ORIGIN:
RELIGION:	FIRST LANGUAGE:
LEGAL STATUS:	
NEXT OF KIN:	TELEPHONE:
ESTIMATED TIME AT CURRENT PLACEMENT:	DIAGNOSIS:

NATURE OF CURRENT CRISIS:

EVALUATION AND RISK SHEET

Please indicate whether any of the following apply to the service user; and if you have answered 'Yes' to any question, the level of support needed:

Level 1 = Low

Level 2 = Medium

Level 3 = High

Level 4 = Very High

Previous Living Environment

Level	LEVEL					
	Yes	No	1	2	3	4
Has the service user lived independently within the last 5 years?						
Has the service user lived in a supported living (i.e. group home) environment within the last 5 years?						
Does the service user require prompting with daily living skills?						
What level of independence is the service user attaining at present?						
Has the service user been hospitalised or institutionalised within the last 5 years?						

Social Background

	LEVEL					
	Yes	No	1	2	3	4
Does the service user have a past history of social isolation?						
Has there been a lack of guidance or role models in the service user's lifestyle?						
Has the service user associated with pro criminal peers and participated in reckless activity?						
Does the service user lack age appropriate friends?						

Medical history / background

	Yes	No	
Is the service user under any Government section code?			Please indicate code:
Is the service user under any medical/ professional body i.e. CPN, Physiotherapist, O.T., Psychiatrist, Speech or Language therapist?			Please indicate:

Medical history/ background cont:

Domiciliary Care. Please indicate if any of the following apply:

LEVEL

	Yes	No	1	2	3	4
Full mobility						
Use a wheelchair						
Wear a medical appliance i.e. stoma bag, catheter etc						
Need assistance standing, lifting, bathing, walking						
Able to self medicate						

Mental Health

LEVEL

	Yes	No	1	2	3	4
Mental health issues						
Experiences difficulties with self identity						
Inappropriate self esteem e.g. too low						
General mistrust in others						
Displays discriminatory attitude						
Is affected by emotional difficulties e.g. sleeping or eating						
Medically diagnosed with ADHD, Aspergers Syndrome, MS, Cardio vascular disease, etc			Please indicate:			
Alcohol or drugs misuse						
Arson related incidents						
Poor control of temper						
Need for excitement (easily bored)						
Aggression towards others						
Damage to property						
Lack of understanding of consequences						
Impulsiveness						
Displays sexually inappropriate behaviour						
Attempts to manipulate / control others						

Substance use

Please fill in table

	Tobacco	Alcohol	Solvents	Cannabis	Class A	Class B	Other
Ever used							
Recent Use							
Age Of Use							
Don't Know							

If class A or B drugs, please specify below on type, use and any treatment. Please list any health issues or treatment of service user below:

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Risk of Harm to Self and Others

Is there any evidence to any of the following?

LEVEL

	Yes	No	1	2	3	4
Behaviour causing serious harm to others						
Intention to cause harm to others						
Behaviour that could lead to harming others						
History of self harm						
Attempted suicide						
Attitude towards harming others						
Behaviour causing harm to other young people						
Intention to cause harm to other young people						
Harm to the general public						
Poor behaviour when travelling in vehicles						

If 'yes' to any of the above, please explain below:

Vulnerability

Is there any evidence of the following?

- a) History of abuse

- b) Risk taking other than previously mentioned

- c) Restrictions on contact

Family and friends

	LEVEL					
	Yes	No	1	2	3	4
What level of input is the service user supported by family and friends?						
Are the family / friends supportive if the service user moves out of borough?						
Is the service user under any Advocacy / Guardianship/ Appointeeship?			Please indicate:			

Significant People

G.P:	Telephone:
Address:	Fax:
Psychologist:	Telephone:
	Fax:
Dentist:	Telephone:
	Fax:
Others:	Telephone:
	Fax:

Physical Appearance

Height		Weight		Build	
Eye Colour		Complexion		Skin Colour	
Hair Colour		Marks/Scars		Glasses wearer	Yes / No
Accent/Speech		Other			

Please detail any additional information not included above:

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AMOUNT OF SUPPORT REQUIRED (PLEASE CIRCLE)

LOW MEDIUM INTENSE (24 HOUR) RESPITE

How many hours per day support required, (i.e. 24 hr 1-1)

The information I have given above, is correct to the best of my knowledge and information received.

NAME:.....

SIGNED:.....

POSITION:.....

DATE:.....