ANDERSEN HOUSING

REFERRAL FORM

Important Information:
Please complete this Form giving as much detail as possible. Failure to do so may result in delays in processing your application or a rejection of the application.

Date:		
Reference:		
Client's Full Name:	Name(s)	Surname
Service Required:		
Date of Birth:		
Address:		
Social Worker (SW):		
SW Contact No:		
SW Email:		

Type of Accommodation (*please tick*)

Approved Premises		Temporary Accommodation		Hostel	
No second Night Out (NSNO) Hub		Rough sleeping		Family/Friend	
Detox Unit		Rehab Unit		Advocacy	
Prison		Assessment Centre		Supported Housing (24 hrs)	
Supported Housing (Semi Independent)		Supported Housing (Visiting/Floating)		Hospital	
Other		If other/hospital *please give details:*			

Next of Kin details (mandatory)

Name of next of Kin:	
Address:	
Relationship:	
Telephone Number.:	
Placing Authority (PA):	
PA Contact No:	
PA Address:	

Placement Start Date:	
Projected End Date:	
Client Status:	
National Insurance No:	
Children's Act Section:	
Nationality:	

Immigration Status *(applicable to non English nationals):*	Do you have Leave to Remain in the UK?						
	Status:	Indefinite Leave		Limited Leave		Refused Leave	
Are there any conditions attached to your Leave to Remain in the UK? *(If YES, please give details):*							
Do you have recourse to public funds? *(If YES, please give details):*							
Country of origin:							

When did you first arrived in the UK	Date:		Month:		Year:	

Have you lived outside the UK within the last 5 years? *(If YES, please provide details, countries resided and dates)*	**Country lived**	**From**	**To**
Please give any other relevant information you wish to disclose relating to your Immigration status in the UK:			

Solicitor(s):	
Solicitor's Address:	
Solicitor's Contact Number:	
Solicitor's Email Address:	

Client History: Please complete, providing as much detail as possible...

1. Family Details:	

2. All Past Placements/Accommodation:

Type of last settled accommodation	Council property/RSL		Privately rented		With Partner:	
	Parents/Family Home		In Care		Other:	

Housing History
Please provide details of your housing history over the last 5 years. *(Please also include details of any time spent in hospital, prison or periods of rough sleeping).*

Reason(s) for leaving should include: antisocial behaviour, abandonment, escaping violence, hospital admission, inability to cope, noise nuisance, mobility issues, period in custody, relationship breakdown, rent arrears, etc.

Address	**From**	**To**	**Reason(s) for leaving**

3 (a) Reason for referral: This section *can be completed by the applicant or the referring agent.* *If you are the referring agent, please state also how long you have worked with the individual and in what capacity.*	

3 (b) Reason for Placement Request: Please include the reasons you feel that Supported Housing would be beneficial to you.	

3 (c) Support

Primary Support Need (please only tick one answer)

Young Person		Mental Health		Sex Worker	
Older Person		Alcohol Misuse		Asylum Seeking	
Care Leaver		Learning Disability		Rough Sleeping	
Physical Health		Substance Misuse		Ex or current Offender	

Are you fleeing violence? *(If YES, please specify)*	
Dual Diagnosis: *(If YES, please specify)*	
NB: If the receiving agent needs to be aware of perpetrators' violence, please provide details:	

Secondary Support Need (please tick as many as applicable to your situation)

Young Person		Sex worker		Mental Health	
Older Person		Learning Disability		Alcohol Dependency	
Relationship breakdown		Social Isolation		Drug Dependency	
Care Leaver		Financial Problems		Rough Sleeping	
Refugee		Physical Health		Offending	

Are you fleeing violence? *(If YES, please specify)*	
Dual Diagnosis: *(If YES, please specify)*	
Additional Information *(if applicable)*	

4. Health Status:

4 (a) **Physical Health**

Please give details of the nature and severity of any physical health issues:

Please give details of treatment the client is currently receiving:

How is the client managing at the moment?

Is the client taking any medication?

What happens if the client does not take his/her medication?

How does the client physical health impact on his/her daily routine?

Does the client uses mobility aids?

Are there any specific requirement in the accommodation with regards to the client's health? *If yes, please give details:*

Are there any risks associated with their physical health issues?
(If yes, please give details):

Is the client in receipt of DLA or PIP?
If yes, please give details (please include in your answer the rate of DLA/PIP the client is claiming and whether it is related to his/her physical health):

Is the client using/have s/he used DLA/PIP package to provide additional care?
If yes, please give details:

Would the client be willing to use his/her money for a care package?
If yes, please give details):

Any other relevant information *(please give details)*:

4 (b) **Substance Use** (*Please complete this section if applicable to you*)

Alcohol User		Drug User		Poly user (both)	
Is the client abstinent over 3 days?			Yes		No

(How long has the client been abstinent and/or if he/she has had period of abstinence in the past. Please give details of how abstinence could be verified - i.e. if client had regular testing or self - reported)

Are there any triggers that can result in relapse? *(if yes, please give details)*

Main substance:		**Age first used:**
Street illicit:	Prescribed by GP:	Prescribed substance Misuse service:
Prescribed & illicit:	Purchased legally:	Other prescribed:

Frequency of use:		Weekly spent:	

Route of Administration

Inject		Sniff		Smoke		Oral		Other *(please specify)*	

Second substance:		Age first used:
Street illicit:	Prescribed by GP:	Prescribed substance Misuse service:
Prescribed & illicit:	Purchased legally:	Other prescribed:

Frequency of use:		Weekly spent:	

Route of Administration

Inject		Sniff		Smoke		Oral		Other *(please specify)*	

Third substance

Street illicit:	Prescribed by GP:	Prescribed substance

		Misuse service:
Prescribed & illicit:	Purchased legally:	Other prescribed:

Frequency of use:		Weekly spent:	

Route of Administration									
Inject		Sniff		Smoke		Oral		Other *(please specify)*	

ALCOHOL USE					
Alcohol Dependant	Yes		No		Age first used
Details of Alcohol: Type & units					
Frequency of use:					

Additional Information:

Is the client currently accessing support/treatment:

If YES, please give details including what support/treatment the client is receiving. How long has he/she been accessing support/treatment. Please include any contacts within the 'support services involved in the clients current support' section.

How does the client behaves under the influence of drugs or alcohol?

Are there any risks associated with the substance misuse?

(If YES, please give details)

4 (c) Mental Health

Mental Health Diagnosis as confirmed by a MH professional	Yes		No	
Is the client linked to CMHT?	Yes		No	

Is the client affected by any of the following? (please tick which ones)

Anger Management		Forensic Mental Health		Personality Disorder	
Anxiety		Home Secretary Restriction Order		Schizophrenia	
Bipolar		In Hospital		Self Harm	

Care Programme Approach (CPA)		On Depot		Social Phobia	
Delusional Thoughts		Oral Medication		Suicide Attempts	
Depression		Panic/Anxiety Attacks		Suicidal Ideation	
First Episode Psychosis		Paranoia		Receiving outpatient Treatment	

Please provide any additional information relating to your Health Condition which you want us to be informed about (if applicable).

Is the client engaging with mental health services?	Yes		No	
(If YES, please provide details)				
Has the client previously been linked to Mental Health Service?	Yes		No	
(If YES, please provide details)				
Has the client ever been sectioned?	Yes		No	
(If YES, please provide details)				
Is the client taking medication or engaging in treatment?	Yes		No	
(If YES, please provide details including what happens if the client does not take his/her medication)				

Please provide information about your medication

Name of Medication	Frequency	Administration Route (eg. depot/oral etc.)

Are there any specific effects/triggers if the client becomes unwell?
(If YES, please give details)

What behaviour/signs indicate that the client is becoming unwell?

Are there any risks associated with their mental health?	Yes		No	

If YES, please provide details:

PRESENTING ISSUES:

5. Primary / and or Secondary

PRIMARY *(PLEASE TICK ONLY ONE)*		***SECONDARY*** *(PLEASE TICK THE ONES THAT APPLY TO YOU)*	
Mental health / personality disorder		Mental health / personality disorder	
Aspergers syndrome		Aspergers syndrome	
Learning disability		Learning disability	
Physical disability		Physical disability	
Brain injury		Brain injury	
Alcohol misuse		Alcohol misuse	
Drug misuse		Drug misuse	
Care leaver		Care leaver	
Homelessness		Homelessness	

6. Education:

Name of educational institution	Dates of Attendance From	To	Qualification gained

CARE & SUPPORT REQUIRED (TICK ALL THAT APPLIES)

Does he/she require assistance with any of the following areas? Please indicate level of assistance required H= High **M** =Medium **L** =Low **N** = None

Assistance required	H	M	L	N		H	M	L	N
Budgeting					Behaviour/anger management				
Paying bills					Medication/prescriptions				
Accessing benefits					Registering with primary care services				
Domestic life skills					Physical health care problems				
Personal hygiene					Nutrition/weight				
Health & safety in the home					Family mediation				
Escorting					Neighbours/peer mediation				

Accessing social& recreational activities					Vulnerable to exploitation				
Language and or literacy					Mobility				
Access to education & employment					Religious/cultural				

Fax ☐ Email ☐ Post ☐ N/A ☐

OTHER ASSISTANCE REQUIRED:

OTHER ISSUES: *Please give detail of other identified care and support needs* ***OR*** *submit up to date care or pathway plans with details. Please indicate if latter to be sent:*

RISK ASSESSMENT

Assistance required	H		M		L		N/A	
Arson								
Physical violence (to others)								
Verbal Aggression								
Damage to property								
Alcohol abuse								
Drugs/Substance abuse								
Sexual behaviour (risk to others)								
Risk to self/Self harm/Overdose								
Risk to Others								
Risk of Abuse from Others								
Criminal behaviour								
Schedule 1/Dangerous Offer/MAPPA client								
Non-cooperation with staff								
Mental Health								

Damage to property								
History of rape or sexual assault								
Female lone working considered unsafe								
Sleep disturbance/Nocturnal difficulties								

OTHER RISK ISSUES: Please give detail of other known risk to self or others **OR** submit up to date Risk Assessments with details:

Please indicate if latter to be sent by:

Fax ☐ **Email** ☐ **Post** ☐ **N/A** ☐

We operate a Lone Workers Policy for outreach support workers; if you are aware of any reasons why this may be unsafe, please state below:

Details of identified risk *(please include details of last known incident and frequency of risk):*

Who is at risk? (Please tick as many as is applicable to you and provide details where appropriate)

Client	
Staff	
Visitors/Neighbours	
Contractors	
Specific individual(s)	

Please specify/ provide details as to who is at risk:

Risk Assessment Action Plan

Please state triggers or behaviour to be aware off:

7. Employment/ Training:	Name and address of Employer	Employment From	Employment To	Reason(s) for leaving

8. Racial & Cultural Background:				
9. Interests & Hobbies:				
10. Past incidents of Violence/ Damage:				
11. Criminal Record:	Do you have any Criminal Conviction(s)?			

Offending History

Is/has the client been linked to any probation or youth offending service?
If you answered YES, please provide the probation/youth officer's details (name and address of officer, how often the client sees the officer)?

Has the client been convicted of any of the following offences?

Arson ☐

Violence ☐

Sexual Offence ☐

If you have ticked any one of the boxes above, please provide details:

Has the client ever been a registered sex offender?
If YES, please provide details:

Is the client known to Multi Agency Public Protection Arrangements (MAPPA)?

Please state the offence the client has committed and the Category/Level of offence:

Is the client on any of the following Orders? *(Please attach any probation/youth offending service documents with Form, if applicable).*			
Anti Social Behaviour Order (ASBO)		Intensive Supervision and Surveillance	
Community Order		License	
Detention and Training Order		Referral Order	
Drugs Rehabilitation Requirement		Suspended Sentence Order	
Home Detention Curfew (HDC)/Tag		Youth Rehabilitation Order	
Other (Please give details):			
Date License/Date Order ends:			
Please give any other offence which the client have not previously mentioned and provide details, including date offence was committed, sentence or community orders received.			
Is the client attaching the necessary probation documents with this application? *(If NO, please give reason)*			

12. Pending Cases: Serious Untoward Incidents & Safeguarding	Please give details of any Serious Untoward Incidents & Safeguarding involving this client in the last 3 months and/or whether there are any safeguarding alerts in the last 12 months that may be relevant.				
13. Benefits or Income:	Is the client in receipt of benefits?	Yes		No	
	Please list the benefits and the amount receiving:				
	Has a claim for the benefits been made and a decision pending?	Yes		No	
	Does the client have a bank account?	Yes		No	

	Is the client in paid employment?	Yes		No	
	Does the client have any savings?	Yes		No	
	Does the client have outstanding debt problems? If Yes, please give details:	Yes		No	
	Has the client's income been affected by changes to benefits If Yes, please give details:	Yes		No	
	Does the client have any rent/service charge arrears? If Yes, please give details:	Yes		No	
	Is there a payment plan in place? If Yes, please give details:	Yes		No	
14. Specific Requirements:					

		Always	Sometimes	Not at all
15. Support required to live independently	Personal care			
	Accessing other Services			
	Accessing education/training			
	Accessing employment			
	Applying for welfare benefits			
	Paying rent and utility bills			
	Independent living (cooking, cleaning, shopping)			
	Literacy support			
	Language and translation			
	Taking medication			
	Dealing with isolation			
	Engagement with support			
	Spending time with family and friends			
	Looking after children			
	Looking after partner, parent or other			

	family members			
	Cultural or spiritual activities			
	Leisure activities			
	If you have ticked "Always" or "Sometimes" please indicate what support is required			

16. Support Services involved	Please provide any Support Services involved in the client's current support		
	Name of Support Service(s) (eg. GP/CMHT/YOS)	Contact Name	Contact Address, Telephone Number and Email

17. Client Consent

In order to help you access Care ☐ Support Services ☐ Advocacy ☐ *(please tick the one(s) applicable to you)* Andersen Housing requires your consent to access information about you from other persons/ agencies/bodies such as your Social Worker, GP, Probation Officer, Housing Benefit, etc.

Information that you have provided to us, will also be only be shared with other service agencies who are working along with us in assisting you.

In order to ensure your safety and the safety of others, we will also complete a risk assessment which may be shared with other service agencies. Information will only be shared on a need to know basis where there is specific and legitimate need to do so.

We will only share information about you with other service agencies who will be able to assist you efficiently and effectively.

I ____________________________ (acting on behalf of) ____________________________ have agreed that the information provided on this Form is accurate.

____________________________ ____________________________

Signature **Date**

Weekly Accommodation Fee:	
Daily Accommodation Fee:	
Support Hours per Week:	
Subsistence per Week:	
Key work session Fee:	
Purchase Order No:	
Authorised By:*	
Your Email Address: *	
Contact Number:	
Invoice Address:	

Authorisation:	
Placement Authorising Officer:	
Signature:	
Date:	
ANDERSEN HOUSING OFFICE ONLY:	
AH Officer:	
Signature:	
Date:	