# CARASTON HALL

## SUPPORT, HOUSING AND HISTORY REFERRAL FORM

Please answer all relevant questions

| Is the prospective client aware of this referral? | YES | NO |
|---|---|---|

**Please tick below which service is required**

| | | | | | |
|---|---|---|---|---|---|
| **PERSONAL CARE** | | **SUPPORT & ACCOMMODATION** | | **ENABLING** | |
| **RESPITE** | | **OTHER Please state:** | | | |

| | |
|---|---|
| Forename(s): | Date of birth: |
| | Age: |
| Surname: | N I no: |
| | Next of Kin: |
| Address: | Address of next of kin: |
| | |
| Postcode: | Postcode: |
| Contact Tel No: | Tel No: |
| Gender: | Relationship: |
| Marital Status: | Is the prospective client eligible for 117 aftercare |

| **Housing information:** | |
|---|---|
| Present Accommodation Status/ Housing Needs: | |
| Details of previous housing benefit claims: Address, Tenancy start and Finish date | |

| **Clinical information:** | |
|---|---|
| Registered Disabled: If Yes please specify nature of disabilities | |
| Ethnicity (please circle or state) | White British, White Irish, White Other (please specify) Black British (African), Black British (Caribbean), Black British (other), Mixed Background, Asian British (Bangladeshi), Asian British (Indian), Asian British (Pakistani) Asian British (other), Chinese, Refused/Knot known |
| Current Medication: | List current medication: |
| Is the person being referred compliant with their medication: | |
| Is the person being referred self managing with their medication administration: | |
| Outline of current mental health issues: | |
| Details relating to any diagnosis of Learning Disabilities: | |
| Details relating to Substance misuse: | |
| Current smoker status? | How many per day: |
| Current use of alcohol: | Units: Frequency: Day/week |
| Current Treatment Programmes: | |

| | |
|---|---|
| GP Name: | |
| Surgery Address: | |
| Consultant Name: | |
| Recovery Coordinator Name: | |
| Hospital/team Address: | |
| Referrers Name: | |
| Address: | |
| Tel No: | |

## Benefits Information

| Type of benefit in receipt of | In process of claiming | | Please state amount & how often paid |
|---|---|---|---|
| Income Support: | | | |
| Employment Support allowance: | | | |
| Job Seekers Allowance: | | | |
| Housing Benefit: | | | |
| Council Tax Benefit: | | | |
| **Personal Independent payment** | **Standard** | **Enhanced** | |
| Daily living component: | | | |
| Mobility component: | | | |
| | | | |
| Private Pension | | | |
| Widows Pension | | | |
| Statutory Sick Pay | | | |
| Other Benefit please specify | | | |
| Any savings which may affect benefits | Yes/No | | |

## General Support Needs

Identifying support needs allows Caraston Hall to offer the most appropriate support to meet the needs of individuals.

| What are the support needs identified? (Please tick boxes YES or NO) | YES | NO |
|---|---|---|
| Life Skills | | |
| Mental Health | | |
| Learning Disabilities | | |
| Finances/Budgeting/Benefits | | |
| Social Skills | | |
| Accommodation Needs | | |
| Advocacy | | |
| Signposting (move on support with resettlement) | | |
| Education/Employment/Training | | |
| Other (please specify) | | |

Please explain in further detail identified support needs:

## Other Agencies/Services Involved

| | NAME | Tel No | | NAME | Tel No |
|---|---|---|---|---|---|
| Housing officer | | | Consultant | | |
| Carer | | | Probation | | |
| Social Worker | | | AA Worker | | |
| R&IL/AOT/Rehab | | | ENDAS | | |
| Learning Dis Team | | | Other | | |

## Mental Health

**Assessment and history of clients needs in the following areas:**

| | |
|---|---|
| **Behaviour and expression:**<br>Describe behaviour that may impact on others.<br>e.g. Verbal/physical aggression<br>Self harm<br>Withdrawal | |
| **Mental health history:**<br>Details of hospital admissions<br>Section status<br>Diagnosis | |
| **History of harming behaviours to self or others:** | |
| **Ability to ask for support when needed:** | |
| **Clients own perception of their Mental Health**: | |
| **Are there any mental Capacity concerns / issues identified?** | |
| **Is the person being referred subject to any DOLs or intervention from the Court Of Protection?** | |
| **Choice and control:**<br>Is the person being referred able to make choices in all aspects of their lives? | |
| **Risk and Safety:**<br>Are there risks to personal safety, vulnerability and Safety of others? | |

## Activities of daily living

| **Tasks** | Independent | Prompting | Direct support |
|---|---|---|---|
| Maintaining Room/cleaning | | | |
| Laundry | | | |
| Preparing snacks and drinks | | | |
| Full meal preparation/cooking | | | |
| Shopping | | | |
| Structuring daily routine | | | |
| Managing own budget/money | | | |
| Managing personal hygiene | | | |
| Taking Medication | | | |

## Relationships and social inclusion

| | |
|---|---|
| **Social Interests:** | |

| | |
|---|---|
| | |
| **Religious & Cultural Needs** | |
| **Friends and family Involvement:** | |
| **Details of work experience or interests:** | |
| **Education and training/meaningful Occupation needs:** | |
| **Physical Health** | |
| **Overview of Physical well being:** | |
| **Allergies/dietary needs i.e.** **Special Diet, Diabetic, Cultural/Relig needs, Vegetarian** | |
| **Hearing/coordination/ Communication/sight** | |
| **Oral health:** | |
| **Personal Care:** | |
| **Mobility or dexterity:** | |
| **Medical conditions/diabete Epilepsy/other:** | |

**I have read the entire referral details and I can verify that the information is true to my knowledge and I have attached a summary of risk relating to the individual being referred.**

**Person Referring**

Name:……Service/Team (if applicable):……

Signature:……..Date:……

Client Name:……

Signature:……..…… Date:……