FLOATING SUPPORT REFERRAL FORM

A referral can only be accepted if it is clear that the applicant knows and agrees to be referred. Please ensure that you have fully discussed the Floating Support Service with the Client before making a referral.

Date of Referral____________________

Referred by_______________________

Name of organisation _______________

Referral Book No *(Office use only)*_______

Contact number ____________________

CLIENT DETAILS

Name: ___________________________

Current address:____________________

____

Postcode: _______________

Nat Ins No: ________________________

D.O.B.____________________________

Telephone Number:_________________

Mobile Number: ____________________

TYPE OF SUPPORT REQUIRED (Please indicate the type of support required by ticking all the relevant boxes)

- ☐ MOTIVATION/ TAKING RESPONSIBILITY
- ☐ SELF CARE AND LIVING SKILLS
- ☐ MANAGING MONEY AND PERSONAL ADMINISTRATION
- ☐ SOCIAL NETWORKS AND RELATIONSHIPS
- ☐ DRUG AND ALCOHOL MISUSE
- ☐ PHYSICAL HEALTH
- ☐ EMOTIONAL AND MENTAL HEALTH
- ☐ MEANINGFUL USE OF TIME
- ☐ MANAGING TENANCY AND ACCOMMODATION
- ☐ OFFENDING

REASON FOR REFERRAL **(Please note that the client may be put on a waiting list, it is therefore vital that you give as much information as possible to allow for prioritisation)**

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SOURCE OF INCOME

Are you employed?	☐ Yes	☐ No
Are you in receipt of benefits?	☐ Yes	☐ No
Any difficulties with claiming benefits	☐ Yes	☐ No

If yes please state which benefits

____
____

CLIENT ISSUES **(Please indicate which of the following applies by ticking all the relevant boxes)**

- ☐ Chronic health condition
- ☐ English is not first language
- ☐ Homeless/temporarily housed
- ☐ Learning disability
- ☐ Not in education, training or work (NEET)
- ☐ Not in work or training (adult)
- ☐ Parent (with children under 18)
- ☐ Physical disability
- ☐ Refugee or asylum seeker
- ☐ Sensory impairment
- ☐ Teenage parent
- ☐ Victim of domestic abuse
- ☐ Other

RISK ASSESSMENT **(Please tell us about the known risks, if any, to the applicant or to others.)**

Does the person present as a risk to themselves or others ☐ Yes ☐ No

Is it recommended that this person be visited in pairs ☐ Yes ☐ No

Please provide details of suicide attempts, self-harm, violence/aggression.

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OTHER SERVICES INVOLVED **(Social Worker /CPN / Counsellor/ Health visitor/ Other)**

Contact with other agencies? ☐ Yes ☐ No

If YES which agencies?

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____
____
____

We will contact you to confirm acceptance of your referral. Please help to avoid delay by keeping us up to date with any changes in circumstances or contact numbers for you or the applicant.

(Office use only) ACCEPTED ☐ Yes ☐ No

Reason for Refusal

____
____

Date Referrer notified______________________ Signed FSO_________________________

Please forward referral form to:

Floating Support Team
Apex Housing
10 Butcher Street
Derry / Londonderry
Northern Ireland
BT48 6HL
Telephone: +44 2871 360728
Fax: +44 2871 304801
Email: floatingsupportvm@apex.org.uk