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|  | **Community Response Referral Form**  |
| Date of Referral:  | New Referral: Yes / No | Client Reference Number : (Office Use Only) |
| Name of Referrer: | Name of Referrer Organisation:  |
| Position: | Telephone No: |
| Address: | E-mail address: |
| Has the original adult protection concern been resolved? YES / NO  |
| Has the client consented to referral? YES / NO *If no, please explain why.*  |
| **PERSONAL CIRCUMSTANCES OF CLIENT** | YES | NO | Don’t Know |
| Is the person over 60 years of age? |  |  |  |
| Does the person live in Scotland? |  |  |  |
| Does the person have an identified mental health issue or learning disability? |  |  |  |
| Are there any risk factors? i.e. is the abuse still continuing |  |  |  |
| **CLIENT CONTACT DETAILS** |
| Name :Date of Birth : / / Age: Gender:Address:Marital status: | Telephone:Mobile:**Safe to call / text / leave a message**: YES / NO  |
| **DETAILS OF THE ABUSE** **(**please include where, when, and type of abuse) Please continue on a separate sheet if necessary. |
| ***Known risk factors:***  |
| **Is the client still in an abusive situation?** YES / NO **Is the client still in contact with the perpetrator?** YES / NO **Perpetrator Details (if known)**:*Name:* |
| *Relationship to Victim:* | *Age:* | *Gender:* |
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| **CIRCUMSTANCES WE NEED TO BE AWARE OF**  | **YES** | **NO**  | **DON’T KNOW** |
| Diagnosed major depression or anxiety, short term memory loss or dementia |  |  |  |
| Hearing Impairment |  |  |  |
| Visual Impairment |  |  |  |
| History of Falls |  |  |  |
| Housebound, poor mobility, or unable to go out alone |  |  |  |
| Does the person have any other identified disabilities such as Alzheimer’s? |  |  |  |
| Does the person live alone? |  |  |  |
| Is there a history of self-harm? |  |  |  |
| If the person lives with a dependant, is that dependant considered ‘vulnerable’? |  |  |  |
| Does the person have very little contact with family members? (E.g. Once or twice a year.) |  |  |  |
| Does the person live with a family member but still feel isolated? |  |  |  |
| Does the person lack confidence to access the community on his/her own? |  |  |  |
| Is the person able to give consent to having a volunteer? |  |  |  |
| Any known substance abuse issues?  |  |  |  |
| Any physical or learning disabilities?  |  |  |  |
| *If answered yes to any of the above questions, please supply further information* |
| **Please list all professionals/services known to be involved with person i.e.** Adult Protection, Police, Adult Social Services, GP, Community Mental health team |
| **Any other Comments:**  |

Please return the completed form to:
Hourglass Scotland Community Response Team
scotland@wearehourglass.org