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REFERRAL FORM

INFORMATION ABOUT THE PERSON WHO WANTS THE SERVICE

What type of Shared Lives service is being requested? (please select)

- ☐ A long term Shared Lives service
- ☐ A short break service
- ☐ Home from hospital (if this box if ticked please fill in the relevant information on page 2)
- ☐ Day time services
- ☐ Just Next Door (semi-independent living)

Last name		Title	
Forenames (s)		Likes to be known as	
Current Address		Gender	
		Date of birth	
Telephone		Nat Insurance no	
		NHS no	
Next of Kin/carer		Social/Care worker	
Name		Name	
Relationship		Team	
Address		Address	
Telephone		Telephone	
Email		Email	
GP name or Medical Centre contact details (if known)			
Who is the main correspondent for the purposes of this referral?			

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REFERRAL FORM

INFORMATION ABOUT THE PERSON WHO WANTS THE SERVICE

Please tick any boxes that describe the person's current situation:

- ☐ Is a young person in transition from foster care
- ☐ Is currently living at home with parents/family
- ☐ Is currently in a residential school or college
- ☐ Is currently living alone
- ☐ Is currently living in a residential care home
- ☐ Is currently in a short stay/respite setting
- ☐ Is currently living in a supported living tenancy
- ☐ Is currently assessed under a section of the Mental Health Act (section 2,3 or 117)
- ☐ Health/Home from Hospital
- ☐ Other (please describe below)

……

Please tick the statement that relates to the PRIORITY NEEDS for the person who wants the service – this is to identify the MAIN support need, other needs can be identified below:

☐ Learning disability	☐ Is a person over age 60
☐ Mental health issues	☐ Physical disabilities
☐ Dementia	☐ Sight impairment/is non sighted
☐ Hearing impairment/deaf	☐ Acquired brain injury
☐ Autism	☐ Reablement from hospital

If this is a Home from Hospital referral please complete the section below.
If not continue to page 3.

Name of hospital			
Name of ward		Phone number	
Other professionals involved		Professionals contact details	
Intermediate Care Team/Discharge team contact details			
Estimated date of discharge		Is this person medically fit for discharge?	

Is there a discharge plan in place:

- ☐ Yes
- ☐ No

Please enclose with the referral

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REFERRAL FORM

INFORMATION ABOUT THE PERSON WHO WANTS THE SERVICE

Please describe the ethnic origin of the person requesting the service				
Asian or Asian British	**Black or Black British**	**Mixed**	**White**	**Other ethnic group**
☐ Indian	☐ Caribbean	☐ White and Black Caribbean	☐ British	☐ Chinese
☐ Pakistani	☐ African	☐ White and Black African	☐ Irish	☐ Any other ethnic group
☐ Bangladeshi	☐ Any other black background	☐ White and Asian	☐ Any other White background	
☐ Any other Asian background		☐ Any other mixed background		

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REFERRAL FORM

FURTHER INFORMATION ABOUT THE PERSON WHO WANTS THE SERVICE

Where does the person wish to live (for long term service requests) Please specify any geographical areas that would be considered/ would definitely not be considered.

For Short breaks/Home from Hospital: what areas would the person consider travelling to for a Short break/Home from Hospital (including Devon, Torbay, Cornwall, Plymouth and Somerset)

How often would the person like short breaks? e.g one weekend a month.

Ideally what type of household would the person prefer to be in?

- ☐ Prefer to be the only person being supported
- ☐ Would like a household with animals/pets
- ☐ Prefer a quiet household
- ☐ No particular preferences
- ☐ Prefer company of similar age
- ☐ Do not like cats/dogs
- ☐ Prefer an active household

Does the person wanting the service have the mental capacity to understand and make a decision about where they live?

- ☐ Yes
- ☐ No

If not, has a best interest decision meeting been held?

- ☐ Yes
- ☐ No

Please supply any written evidence.

Does the person being supported or the appropriate representative understand how Shared Lives works?

- ☐ Yes
- ☐ No

If no, can we make contact with them?

- ☐ Yes
- ☐ No

Are there any complex family issues/relationships/safeguard issues?

- ☐ Yes
- ☐ No

If yes, please supply details.

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REFERRAL FORM

FURTHER INFORMATION ABOUT THE PERSON CONTINUED

Tell us about the person wanting the service. **e.g. hobbies and interests, weekly routine, family and friends.** **The more you can tell us, the more it will help us to find a match within our service.** ***Please enclose a recent needs assessment/care plan.***
What are the main areas of support that the person requires from the service? **e.g. help with personal care, daily living skills, emotional support**

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REFERRAL FORM

FURTHER INFORMATION ABOUT THE PERSON CONTINUED

Does the person have any specific support needs we should take into account in matching? **e.g. use of stairs, wheelchair user, mobility aids, specific communication needs, night time needs.** ***Please list.***
Are there any areas of risk to the person or to others around them? ***Please provide any risk assessments.***
Can the person be left alone for any period of time?
Is the person currently taking any medication? Do they have any known allergies? ***Please specify.***
Any specific dietary requirements? Is a special diet required? Are there any choking risks and are the speech and language team involved?

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REFERRAL FORM

FURTHER INFORMATION ABOUT THE PERSON CONTINUED

Any specific health issues which will need support? (example- skin integrity concerns)
Are there any continence needs?
Other services used by the person (long term placements only) **Does the person attend any day time /leisure activities that need to be maintained?** ☐ **Yes** ☐ **No** ☐ **Don't know** **If yes, please give details.**
Any other information about the person requesting the service?

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REFERRAL FORM

FUNDING

Who is likely to have funding responsibility for this service?

☐ Local authority commissioned service
☐ Direct Payment/ held by who? Please specify below.
☐ Self-funded by person/other
☐ Health Authority

.....

Is any funding already agreed in principle to meet this service request?

☐ Yes
☐ No

If yes, please give details

.....

The cost of the service will be determined based on the support needs of the individual.

Is the person currently funded under section 117 of the Mental Health Act

☐ Yes
☐ No
☐ Not known

Is the person currently making any contribution to the cost of any of their care?

☐ Yes
☐ No

If yes, how much and on what frequency?

.....

.....

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REFERRAL FORM

THE PERSON'S FINANCIAL SITUATION

Does anyone act as? (tick box)

☐ Appointee
☐ Corporate Appointee
☐ Deputy
☐ LPA

Details of anyone appointed to manage the person's financial/personal affairs on their behalf

Name		Relationship	
Address		Telephone	
		email	

Does the person requiring the service have access to their own bank account?

☐ Yes
☐ No

Does the person requiring the service have a mobility funded vehicle?

☐ Yes
☐ No

Does a financial capacity assessment need to be completed?

☐ Yes
☐ No

If yes, please submit the assessment.

Does the person have any paid or voluntary employment?

☐ Yes
☐ No
☐ Don't know

If yes, please give details

.....

Does the person attend college/educational activity

☐ Yes
☐ No
☐ Don't know

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REFERRAL FORM

THE PERSON'S FINANCIAL SITUATION

We can not progress the referral without some financial information, so please complete as fully as possible.

FOR LONG TERM SERVICES ONLY: Does the person have any capital that you are aware of?

- ☐ Not known
- ☐ Under £16,000
- ☐ Between £16,000 and £20,000
- ☐ Over £20,000
- ☐ Over £23,500
- ☐ Trust fund

FOR LONG TERM SERVICES ONLY Please list the service user's current benefits and sources of income and **provide proof.**		Amount £	How often	Any further information
Universal Credit				
Does that include household costs?		Yes ☐ No ☐		
Employment Support Allowance				
Income Support				
Severe Disablement Allowance				
Personal Independence Payment	Daily Living			
	Mobility			
Disability Living Allowance	Care			
	Mobility			
Pension Credit				
State Retirement pension				
Pension- Occupational				
Other Income				
Earnings from paid employment				

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REFERRAL FORM

The person completing the form needs to sign here:
Signature……
Date……
Print Name ……
Relationship to person……

It is important that the person requesting the service from Shared Lives South West is aware that the information on this form will be shared with staff and some Shared Lives carers from Shared Lives South West in order to find the best match possible in our service. Please make sure this has been discussed and is understood by the person as appropriate.

Signature of person requesting service (where applicable)
……..

Attachments – the more information you can send us, the easy it is for us to find a match.
Please tick any further information/documentation that is attached

- ☐ Current or very recent needs assessment
- ☐ Current or very recent care plan or person centred plan
- ☐ Current or very recent risk assessment
- ☐ Other additional information.
- ☐ MCA/FCA assessments
- ☐ Hospital discharge plan
- ☐ Benefit Information

Please specify.....

RETURNS

Please send your referral form and any additional information by email to:
Devon: enquiries@sharedlivessw.org.uk
Cornwall: cornwall@sharedlivessw.org.uk
Somerset: somserset@sharedlivessw.org.uk

Referrals from Devon County Council, Torbay Council & Plymouth Council or self funders in the county send to:
Referrals, Shared Lives South West, Suite 3, Zealley House, Greenhill Way, Kingsteignton, Newton Abbot, TQ12 3SB. Tel: 01626 360170
Referrals from Cornwall Council or self funders in the county send to:
Referrals, Shared Lives South West, Trewellard Farm, Wheal Rose, Scorrier, Redruth, TR16 5DH. Tel: 01209 891888
Referrals from Somerset Council or self funders in the county send to:
Referrals, Shared Lives South West, The Wagon House, Eaglewood Business Park, Ilminster TA19 9DQ. Tel: 01460 477980

For further details about how we will use your personal information, please read our privacy policy: https://www.sharedlivessw.org.uk/wp-content/uploads/2019/08/Shared-Lives-South-West-Privacy-Policy.pdf