# Referral Form

For all services at SLSW

shared lives south west

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If you need support filling in this document, please contact us and we will do our best to help. Our contact details can be found in Section 12 on this form.

## Section 1- About the person being referred

| | | | |
|---|---|---|---|
| Name | | | |
| Preferred name | | | |
| National insurance no | | | |
| Gender | | Pronouns | |
| Ethnicity | | | |
| Date of birth | | | |
| Telephone number | | | |
| Mobile number | | | |
| Email address | | | |
| Preferred method of contact | | | |
| Address of the person being referred | | | |

## Section 2- About the referrer and service being requested

| | |
|---|---|
| Name of referrer | |
| Referrer email address | |
| Referrer telephone no | |
| How did you hear about us? | |
| Service requested | |
| Location requested | |
| Miles willing to travel for placement | |
| Current situation | ☐ Is a young person in transition from foster care<br>☐ Is currently living at home with parents/family<br>☐ Is currently in a residential school or college<br>☐ Is currently living alone<br>☐ Is currently living in a residential care home<br>☐ Is currently in a short stay/respite setting<br>☐ Is currently living in a supported living tenancy<br>☐ Is currently assessed under a section of the Mental Health Act (section 2,3 or 117)<br>☐ Health/Home from Hospital<br>☐ Other (please describe below) |

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## Section 3- Priority needs

| | |
|---|---|
| Acquired brain injury | |
| Autism | |
| Dementia | |
| Hearing impaired/Deaf | |
| Learning disability | |
| Mental Health - Not Section 117 | |
| Mental Health - Section 117 | |
| Older adult | |
| Parent with LD | |
| Physical disability | |
| Reablement/home from hospital | |
| Sight impairment | |

## Section 4- Accommodation needs

| | Yes | No |
|---|---|---|
| Can live with pets? | | |
| Geography where they would like to live? | | |
| • Rural location | | |
| • Urban location | | |
| • Unknown location | | |
| Smoker? | | |
| If requesting a SHORT BREAK service- how many nights are required and how often. | | |

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## Section 5 - What environment does the person prefer?

| | |
|---|---|
| Calm/quiet | ○ |
| Noisy and active | ○ |
| Varied | ○ |
| Unknown | ○ |

## Section 6 - Who can the person live with?

| | Yes | No |
|---|---|---|
| Young children | | |
| Other supported people | | |
| Other family members | | |

## Section 7 - What are their other needs?

| | Yes | No |
|---|---|---|
| Needs a driver | | |
| Needs wheelchair access | | |

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## Section 8 - Contacts

| | |
|---|---|
| GP name or Medical Centre contact details (if known) | |

| | |
|---|---|
| Name of next of kin/ carer | |
| Relationship with person being referred | |
| Can we contact them? | |
| Address | |
| Telephone number | |
| Email address | |

## Section 9 - Further information

*Please note- this section only needs to be completed if there is NO accompanying Needs Assessment paperwork*

| | Yes | No |
|---|---|---|
| Does the person wanting the service have the mental capacity to understand and decide where they live? | | |
| If **no**, has a best interest decision meeting been held? (please supply written evidence) | | |
| | | |
| Does the person being supported or the appropriate representative understand how Shared Lives works? | | |
| If **no**, can we contact them? | | |
| Are there any complex family issues/relationships/safeguard issues? | | |
| If **yes,** please supply details below. | | |
| | | |

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| Tell us about the person wanting the service. e.g. hobbies and interests, weekly routine, family and friends.<br>The more you can tell us, the more it will help us to find a match within our service.<br>Please enclose a recent needs assessment/care plan. |
| --- |
| |
| What are the main areas of support that the person requires from the service?<br>e.g. help with personal care, daily living skills, emotional support |
| |
| Does the person have any specific support needs we should take into account in matching?<br>Such as specific communication needs, mobility needs, can they safely climb stairs, are they a wheelchair user, do they use any mobility aids, do they have any specific night time needs.<br>Please list. |
| |

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| Are there any areas of risk to the person or to others around them? Please provide any risk assessments, behavioural plans or any other documents that are relevant. |
| --- |
| |
| Can the person be left alone for any period of time?<br>Is the individual at risk of falls? |
| |
| Is the person currently taking any medication? What assistance do they require to collect and take any prescribed medication?<br>Do they have any known allergies?<br>Please specify. |
| |
| Any specific dietary requirements?<br>Is a special diet required?<br>Are there any choking risks and if so are the speech and language team involved? |
| |

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| Are there any specific health issues which will need support? (example- skin integrity concerns, mood fluctuations). |
| --- |
| |

| Are there any continence needs? If so, how are these managed? |
| --- |
| |

| Other services used by the person **(long term placements only)**<br>Does the person attend any day time / education/ leisure activities that need to be maintained? |
| --- |
| ☐ Yes<br>☐ No<br>☐ Don't know<br><br>If **yes**, please give details below |

| Any other information about the person requesting the service? |
| --- |
| |

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## Section 10 - Funding

| Who is likely to have funding responsibility for this service? |
|---|
| ☐ Local authority commissioned service<br>☐ Direct Payment/ held by who? Please specify below.<br>☐ Self-funded by person/other<br>☐ Health Authority |
| **Is any funding already agreed in principle to meet this service request?** |
| ☐ Yes<br>☐ No<br>If **yes**, please give details<br><br>The cost of the service will be determined based on the support needs of the individual. |
| **Is the person currently under section 117 of the Mental Health Act?** |
| ☐ Yes<br>☐ No<br>☐ Not known |
| **Is the person currently making any contribution to the cost of any of their care?** |
| ☐ Yes<br>☐ No<br>If **yes**, how much and on what frequency? |

## Section 11 - The person's financial situation

| Does anyone act as? (tick box) |
|---|
| ☐ Appointee<br>☐ Corporate Appointee<br>☐ Deputy<br>☐ LPA |

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| Details of anyone appointed to manage the person's financial/personal affairs on their behalf | |
|---|---|
| Name | |
| Address | |
| Relationship | |
| Telephone no | |
| Email address | |

| | Yes | No | Don't know |
|---|---|---|---|
| Does the person requiring the service have access to their own bank account? | | | |
| Does the person requiring the service have a mobility funded vehicle? | | | |
| Does a financial capacity assessment need to be completed? (If **yes**, please submit the assessment) | | | |
| Does the person have any paid or voluntary employment? | | | |
| If **yes**, please give details below | | | |
| | | | |
| Does the person attend college/educational activity? | | | |

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*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 | Daily Living | | | |
| | Mobility | | | |
| Disability Living Allowance | Care | | | |
| | Mobility | | | |
| Pension Credit | | | | |
| State Retirement pension | | | | |
| Pension- Occupational | | | | |
| Other Income | | | | |
| Earnings from paid employment | | | | |

## Section 12 - Signatures

| | |
|---|---|
| *Signature<br>*By typing your name on the right you are electronically certifying this document just as if you would physically sign it if it was on paper | |
| Date | |
| Print Name | |
| Relationship to the 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 SLSW 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) | |

I declare that I have fully disclosed to SLSW all known risks associated with the individual referred.

| | |
|---|---|
| *Signature<br>*By typing your name on the right you are electronically certifying this document just as if you would physically sign it if it was on paper | |
| Date | |
| Print Name | |

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## Section 13- Attachments

The more information you can send us, the easier 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 any other documentation

## Section 14 - Returning the Referral Form

Ideally, please send your referral form and any additional information by email:
**Devon:** enquiries@sharedlivessw.org.uk
**Cornwall:** cornwall@sharedlivessw.org.uk
**Somerset**: somerset@sharedlivessw.org.uk

| | Referrals from Devon County Council, Torbay Council & Plymouth Council or self funders in the county | Referrals from Cornwall Council or self funders in the county | Referrals from Somerset Council or self funders in the county |
|---|---|---|---|
| Address | Referrals<br>Shared Lives South West<br>Suite 3<br>Zealley House<br>Greenhill Way<br>Kingsteignton<br>Devon<br>TQ12 3SB. | Referrals<br>Shared Lives South West<br>Trewellard Farm<br>Wheal Rose<br>Scorrier, Redruth<br>Cornwall<br>TR16 5DH. | Referrals<br>Shared Lives South West<br>The Wagon House<br>Eaglewood Business Park<br>Ilminster<br>Somerset<br>TA19 9DQ. |
| Phone number | 01626 360170 | 01209 891888 | 01460 477980 |

## Section 15 - Privacy

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