**Ridley Villas Referral Form**

To submit your completed document, please email it to

[staffridleyvillas@changing-lives.org.uk](mailto:staffridleyvillas@changing-lives.org.uk)

If you have a CJSM Secure E-mail system, please send this form to

[ridley.referrals@changinglives.cjsm.net](mailto:ridley.referrals@changinglives.cjsm.net)

If you have any queries, please contact a member of the Ridley Villas Staff Team on **0191 2329181**

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| **DETAILS OF PERSON MAKING REFERAL** | |
| Referrer’s name |  |
| Organisation name |  |
| Role/ job title |  |
| Contact number |  |
| Contact email |  |
| Date of referral |  |

Is the person aware you are making a referral? Yes

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| **DETAILS OF PERSON BEING REFERRED** | | |
| First name |  | |
| Last name |  | |
| Previous/Other Names |  | |
| DOB |  | |
| **CONTACT INFORMATION** | | |
|  | Details |  |
| Phone |  |  |
| Current Address  Including details of tenure (e.g. home owner, renting?) |  | |
| **ACCESSIBILITY REQUIREMENTS** | | |
| Accessibility requirements?  (e.g. hearing loop, braille documents) | Yes  No  Not sure | If yes, please provide details: |
| Disability/literacy or numeracy difficulties? | Yes  No  Not sure | If yes, please provide details: |
| Is an interpreter required? | Yes  No  Not sure | If yes, please provide details of language(s) spoken: |

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| **CHILDREN OF PERSON BEING REFERRED** | | | | | |
| *Name*  *(Use “Unborn” for unborn baby)* | *G*  *E*  *N*  *D*  *E*  *R* | *DOB/Due Date* | *Does the child live with the person being referred?*  *Y/N* | *Is the child included in this referral?*  *Y/N* | *Does other parent have parental responsibility?*  *Y/N* |
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| **ADDITIONAL INFORMATION** | | | | | |
| Living arrangements and address of child / children  (if different to person being referred) | | |  | | |
| Do the children attend school/nursery?  If yes, will this need to change? | | |  | | |
| Is there Children Social Care involvement?  If yes, provide relevant information and include the social worker details  (e.g. Child In Need, Child Protection, Subject to Care Order) | | |  | | |
| Are any child contact arrangements in place? | | |  | | |
| CYPS involvement?  If yes describe involvement. | | |  | | |
| Are there any significant concerns regarding the children? | | |  | | |

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| **REASON FOR REFERRAL** | |
| Is the person in Drug and alcohol treatment or receiving support at the time of referral or admission with an active care plan in place? |  |
| Does the person have an identified housing related support need?  If yes, do they have outstanding rent arrears with other providers. |  |
| Does the person have children and/or pregnant?  If the children are not currently in their care, is there a plan for reunification? |  |

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| **SUPPORT NEEDS/ VULNERABILITIES** | | | | |
| **Please tell us more about any support needs the person being referred may have:**  **Please tick where appropriate** | | | | |
| Mental Health  Physical Health  Additional Learning Needs | | | Drug Misuse  Alcohol Misuse  Offending | |
| **Please provide additional details if you have ticked any of the above:** | | | | |
| **Mental Health**  *(e.g., diagnosis, prescribed medication, treatment plan, impact on presentation)*  Has the person being referred ever threatened or attempted suicide? |  | | | |
| **Physical Health**  *(e.g., mobility issues, allergies, HIV, Hep C, treatment plans, prescribed medication)* |  | | | |
| **Additional Learning Needs**  *(e.g., sensory, developmental, physical, learning or behavioural)* |  | | | |
| **Drug Misuse**  *(e.g., script, frequent or infrequent drug use including current and historic)* |  | | | |
| **Alcohol Misuse**  **Including Historic & Current**  *(e.g., engaging in services, frequency of use)* |  | | | |
| **Offending**  *(e.g., Details of historic or current offending, risk toward staff or other residents*) | *We are unable to accept referrals for women with serious offending histories including schedule 1 offences and / or arson* | | | |
| **Additional Risk** | Is this person safe to lone work?  If no, provide details:  Are there any other additional safety considerations you would like us to know about? | | | |
| **PROFESSIONALS INVOLVED:**  Does the woman (and children) have professionals involved? | | | | |
| Professional | | Name | | Email / Tel. No |
| Adult Social Worker | |  | |  |
| Children’s Social Worker | |  | |  |
| Health visitor / Midwife | |  | |  |
| Mental Health Workers | |  | |  |
| Substance Misuse Workers | |  | |  |
| Probation Officer | |  | |  |
| Domestic Violence Officer (Police) | |  | |  |
| Domestic Abuse Support Services | |  | |  |
| Other key Support Services | |  | |  |

**Thank you for taking the time to fully complete the referral form**

**You will receive a response from a named member of the team within 72 hours**