**Referral Form**

***(Please complete all sections)***

|  |  |
| --- | --- |
| **Name:**  **Date:** | **Referrers Name:**  **Agency:**  **Tel’ Number:** |
| **Current Address/Contact Details (Inc. Telephone Number):**  **Date You Moved In:** | **Ethnic Origin:**       **Sex:**  **Date of Birth:** |

**Please tell us about your current circumstances by answering the questions below: -**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Are you homeless, about to be made homeless, or of no fixed abode? YES**  **NO**  Please provide information about your current housing circumstances in the space below | | | | | |
| **Do you, or have you had, substance use issues? YES**  **NO**  If **‘YES’** please provide details of your current and previous substance use in the space below | | | | | |
| **Do you have any mental health problems? YES**  **NO**  If **‘YES’** please provide information concerning your mental health in the space below | | | | | |
| **Do you have a history of violence or aggression? YES**  **NO**  If **‘YES’** please provide information below | | | | | |
| **Are there any risk issues? YES**  **NO**  **DON’T KNOW**  *(It is important that we know of any risks to yourself, to our staff who will be working with you, to others or from others. This will help us decide the most appropriate approach to meet your needs)*  If **‘YES’** Please provide details of all known risks:    **Note for referring Agents:**  Please provide a copy of your most recent risk assessment, or alternatively, a summary of the risks you have identified. | | | | | |
| **Support Issues: *(Please indicate all of your support needs)*** | | | | | |
| Income/Benefits |  | Harassment |  | Physical Health |  |
| Paying Bills |  | Neighbour Relations |  | Learning Difficulties |  |
| Budgeting |  | Leisure/Daytime Activities |  | Offending |  |
| Debt |  | Nuisance Issues |  | Education |  |
| Household Tasks |  | Social Isolation |  | Other |  |
| Furnishing/Decorating |  | Employment/Training |  | Other |  |
| Please provide details of these support needs: | | | | | |
| **When do you need this support (e.g. weekly, daytime, evenings, weekends)?** | | | | | |

Please note that by signing this document you are in agreement with the following statement:

**Agency Referrals**

*(Signed on behalf of referring agency)*

**Name:**

**Signature:**

**Date:**

***“I can confirm that the information given within this referral is, to the best of my knowledge, true and accurate.”***

**Signed by Client:**

**Date:**

**To return the form:**

Please post to The Whitechapel Centre, Langsdale Street, Liverpool, L3 8DU

**or** Fax to 0151 207 4093

**or** email to [info@whitechapelcentre.co.uk](mailto:info@whitechapelcentre.co.uk)

**For online referrals** – please visit our website at www.whitechapelcentre.co.uk