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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral Form for ECCS** | | | | | | | | | | |
| **Date of Referral** | | | | | Click here to enter a date. | | | | | |
| **Name of Referral agency, service, LA** | | | | |  | | | | | |
| **Name of Contact** | | | | |  | | | | | |
| **Contact Telephone number** | | | | |  | | | | | |
| **Contact Email** | | | | |  | | | | | |
|  | | | | |  | | | | | |
| **Client Details** | | | | | | | | | | |
| **Name** | | | | |  | | | | | |
| **Preferred Name/ Alias** | | | | |  | | | | | |
| **National Insurance Number** | | | | |  | | | | | |
| **Current Address** | | | | |  | | | | | |
| **Telephone/Mobile Number** | | | | |  | | | | | |
| **Email Address** | | | | |  | | | | | |
| **Borough Responsible for support** | | | | |  | | | | | |
| **Local Authority Responsible if outside London** | | | | | Click here to answer. | | | | | |
| **Referred for** | | | | |  | | | | | |
| **Has Funding been agreed** | | | | | Click here to answer. | | | | | |
| **Ideal Start Date** | | | | | Click here to answer. | | | | | |
|  | | | | | Click here to enter a date. | | | | | |
| **Demographics** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Date of Birth** | **Identified Gender** | | **Marital Status** | | | | **Sexuality** | | | **Ethnic Origin** |
| Click here to answer. | Click here to answer. | | Click here to answer. | | | | Click here to answer. | | | Click here to answer. |
| **Nationality** | **Preferred Language** | | **Interpreter/Signer Needed** | | | | **Refugee/Asylum Seeker** | | | **Legal Situation/Status** |
| Click here to answer. | Click here to answer. | | Click here to answer. | | | | Click here to answer. | | | Click here to answer. |
| **Employment Status** | **Registered Disabled** | | **Type of Disability** | | | | **Special Requirements** | | | **Special Requirements Other** |
| Click here to answer. | Click here to answer. | | Click here to answer. | | | | Click here to answer. | | |  |
| **Religion** | **Smoker** | | **Parental Status (Child under 18)** | | | | **Children living with Client** | | | **Are children on Protection Register** |
| Click here to answer. | Click here to answer. | | Click here to answer. | | | | Click here to answer. | | | Click here to answer. |
| **Accommodation Description** | **Please state if there are any pets** | |  | | | |  | | |  |
| Click here to answer. |  | |  | | | |  | | |  |
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|  | | | | | | | | | | |
| **Next of Kin** | | | | | | | | | | |
| **Relationship** | | | **Contact Details** | | | | | | | |
| Click here to answer. | | | **Name** | | |  | | | | |
| **Address** | | |  | | | | |
| **Tel** | | |  | | | | |
| **Email** | | |  | | | | |
|  | | | | | | | | | | |
| **Primary Need/Reason for Referral** | | | | | | | | | | |
| **Please give details of motivations, goals, and circumstances that have led to this referral - DIALOG** | | | | | | | | | | |
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|  | | | | | | | | | | |
| **Regularity of Support Required** | | | | | | | | | | |
|  | | **AM (9am – 12pm)** | | **Hours** | | | | **PM (12pm -9pm)** | **Hours** | |
| **Monday** | |  | |  | | | |  |  | |
| **Tuesday** | |  | |  | | | |  |  | |
| **Wednesday** | |  | |  | | | |  |  | |
| **Thursday** | |  | |  | | | |  |  | |
| **Friday** | |  | |  | | | |  |  | |
| **Saturday** | |  | |  | | | |  |  | |
| **Sunday** | |  | |  | | | |  |  | |
| **How often is support required** | | | | Click here to answer.. | | | | | | |
| **Are hours required outside of these times? If so, please specify** | | | |  | | | | | | |
|  | | | | | | | | | | |
| **Key Issues** | | | | | | | | | | |
| **What activities of daily living does the client require support with? Please specify** | | | | | | | | | | |
| **Mobility** | | | |  | | | | | | |
| **Financial Matters** | | | |  | | | | | | |
| **Housing and Tenancy** | | | |  | | | | | | |
| **Medication Management** | | | |  | | | | | | |
| **Support to engage in local activities** | | | |  | | | | | | |
| **Support with Alcohol and Substance Misuse** | | | |  | | | | | | |
| **Support to attend meetings and appointments** | | | |  | | | | | | |
| **Assistance with shopping and domestic responsibilities** | | | |  | | | | | | |
| **Personal Care** | | | |  | | | | | | |
| **Befriending** | | | |  | | | | | | |
| **Other…** | | | |  | | | | | | |
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| **GP Contact Details** | | | | | | | | | | | | |
| **Registered with GP** | | **Contact Details** | | | | | | | | | | |
| Click here to answer. | | **Name** | |  | | | | | | | | |
| **Address** | |  | | | | | | | | |
| **Tel** | |  | | | | | | | | |
| **Email** | |  | | | | | | | | |
| **Frequency of Contact** | | | | |  | | | | | | | |
| **Nature of Support** | | | | |  | | | | | | | |
|  | | | | | | | | | | | | |
| **Responsible Clinician Contact Details** | | | | | | | | | | | | |
| **Contact Details** | | | | | | | | | | | | |
| **Name** |  | | | | | | | | | | | |
| **Address** |  | | | | | | | | | | | |
| **Tel** |  | | | | | | | | | | | |
| **Email** |  | | | | | | | | | | | |
| **Frequency of Contact** | | | | |  | | | | | | | |
| **Nature of Support** | | | | |  | | | | | | | |
|  | | | | | | | | | | | | |
| **Social Support Network** | | | | | | | | | | | | |
| **Please list all people including family, friends, agencies and professional bodies including day centres currently involved in supporting client** | | | | | | | | | | | | |
| **Name** | | | | | | | | | **Capacity** | | | |
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| **Physical Health** | | | | | | | | | | | | |
| **Details of medical conditions** | | |  | | | | | | | | | |
| **Details of specialist equipment required for support** | | |  | | | | | | | | | |
| **Medication** | | | **Name** | | | | | **Dosage** | | | **Times Taken Daily** | |
|  | | | | |  | | | Click here to answer. | |
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| **Allergies** | | | Click here to answer. | | | | |  | | | | |
| **Allergy Details** | | |  | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Mental Health** | | | | | | | | | | | | |
|  | | |  | | | | | **Details, if known:** | | | | |
| **Is the Client current on a Section** | | | Click here to answer. | | | | | Date implemented: Click or Type date here.  Conditions/Restrictions? | | | | |
| **Number of admissions under the Mental Health Act** | | |  | | | | |  | | | | |
| **Care Programme Approach (CPA)** | | | Click here to answer. | | | | |  | | | | |
| **Supervision Register** | | | Click here to answer. | | | | |  | | | | |
| **Index Offence**  **(If applicable)** | | |  | | | | |  | | | | |
| **Suicide attempts** | | | Click here to answer. | | | | |  | | | | |
| **History of Self Harm** | | | Click here to answer. | | | | |  | | | | |
| **Diagnosis for Mental Health problems** | | | Click here to answer. | | | | |  | | | | |
| **Frequency of contact with CMHT** | | |  | | | | | | | | | |
| **Medication** | | | **Name** | | | | | **Dosage** | | | **Times Taken Daily** | |
|  | | | | |  | | | Click here to answer. | |
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| **Allergies** | | | Click here to answer. | | | | |  | | | | |
| **Allergy Details** | | |  | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Legal Status** | | | | | | | | | | | | |
| **Is there any relevant forensic history?** | | | | | | | | | | | | |
|  | | |  | | | | **Dates of most recent** | | | **Details** | | |
| **Arson** | | | Click here to answer. | | | | Click or Type date here. | | |  | | |
| **Violence** | | | Click here to answer. | | | | Click or Type date here. | | |  | | |
| **Sexual Crime** | | | Click here to answer. | | | | Click or Type date here.. | | |  | | |
| **Homicide/Manslaughter** | | | Click here to answer. | | | | Click or Type date here.. | | |  | | |
| **Stalking Behaviour** | | | Click here to answer. | | | | Click or Type date here.. | | |  | | |
| **Other** | | | Click here to answer. | | | | Click or Type date here. | | |  | | |
| Click or Type date here. | | |  | | |
| **Are there any current injunctions, court cases, orders, warrants, probation etc.** | | | Click here to answer. | | | | Click or Type date here. | | |  | | |
| Click or Type date here. | | |  | | |
| **Victim of Domestic Violence** | | | Click here to answer. | | | | Click or Type date here. | | |  | | |
| **Perpetrator of Domestic Violence** | | | Click here to answer. | | | | Click or Type date here. | | |  | | |
|  | | | | | | | | | | | | |
| **General Information/Notes** | | | | | | | | | | | |
| **Is there any other information, not covered in the above, that you feel we need to know?** | | | | | | | | | | | |
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| **Consent** | | | | | | | | | | | |
| **Consent is given for this information to be shared with agencies and medical professionals involved in the treatment, as well as for internal data collection and statistical purposes.** | | | | | | | | | | | |
| Signature: | Click here to answer. | | | | | | | | | | |
| Name: |  | | | | | | | | | | |
| Date | Click here to enter a date. | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Next Steps…** | | | | | | | | | | | |
| **Please send completed forms via email to:** | | | | | | | | | | | |
| Veronica Claridi Service Manager  Email: veronica.claridi@socialinterestgroup.org.uk  Mob: 07814285448 | | | | | |  | | | | | |
| **If your area is not covered or you have a general enquiry regarding this service or about Equinox, please contact our team:** | | | | | | | | | | | |
| Service Manager: Veronica Claridi  Mob: 07814285448 / 020 3668 9270  Email: [veronica.claridi@socialinterestgroup.org.uk](mailto:veronica.claridi@socialinterestgroup.org.uk) / [ECCS@socialinterestgroup.org.uk](mailto:ECCS@socialinterestgroup.org.uk) | | | | | | | | | | | |