DESTINY SUPPORT CIC
offering floating support & accommodation in the community

Referral Form

1.Applicants Details:

Title:

Surname: Date of Birth:

Forenames:

Address: National Insurance No:

Postcode: Telephone No:

2. Referred By:

Contact Name: Telephone No:

Organisation:

Address: Date Completing Form:

Email Address:

Is this support part of a Care Package: [ ] Please Specify:

Not Part of a Care Package: [ ]

3a. Service User Primary need: (Please tick ONE box ONLY)

	Tick		Tick
Learning Disabilities		Alcohol/Drug Problems (delete as applicable)	
Mental Health problems		Young Person at Risk	
Sensory/Physical Disability (delete as applicable)		Young Person Leaving Care	
Teenage Parent		Refugees/Asylum Seekers	
Older Person with Support Needs		People with HIV/Aids	
People ar Risk or Exposed to Domestic Violence		Offenders/at Risk of Offending	
Single Homeless/Family with Support		Multiple Needs/Other (please state	

3b Secondary Service User needs: (Please tick)

	Tick		Tick
Learning Disabilities		Alcohol/Drug Problems (delete as applicable)	
Mental Health problems		Young Person at Risk	
Sensory/Physical Disability (delete as applicable)		Young Person Leaving Care	
Teenage Parent		Refugees/Asylum Seekers	
Older Person with Support Needs		People with HIV/Aids	
People ar Risk or Exposed to Domestic Violence		Offenders/at Risk of Offending	
Single Homeless/Family with Support		Multiple Needs/Other (please state	

Please provide any other information regarding the Service User:

4. Description of Support required. Please tick all those that are relevant.

	Tick		Tick
Currently experiencing Domestic Violence/Harassment		Lack of life/parenting skills (delete as applicable)	
Threat of Eviction - due to rent arrears, offending behaviours/anti-social behaviours		Help in managing finances and welfare benefits claims (including managing rent or mortgage arrears)	
Young Person (under 18 years)		Advice, Advocacy and Liaison (including gaining	
Rough Sleeper/transition to new tenancy		Neglect of Self or property that would lead to loss of home	
Vulnerable due to having been institutionalised e.g. prison, hospital, residential care, local Authority Care (please provide date of release)		Employment, Training and Education	

Other - Please specify (including language limitations);

5. Approximate number of support hours required per week, if known:

	Tick		Tick
30 minutes		Over 1.5 Hours to 2 hours	
up to One hour		Over 2 hours to 2.5 Hours	
Between 1 Hour and 1.5 hours		Over 2.5 hours to 3 hours	

Over 3 hours - Please state number of hours required per week:

6. Are there any other Professionals currently working with this Service User? (Please tick all those that apply)

Social Worker		Domiciliary Care	
Community Psychiatric Nurse		District Nurse	
Occupational Therapist		Other Professional Worker (Please State)	
YOT Key Worker			

Please provide contact details for the Professional:

7. Known Risk Issues:

Does the Service User present a known risk to her/himself or others?

Yes ☐ No ☐

If Yes, pleade give details:

8. Referrer's Signature: **Date:**

Ethnic Minority Monitoring Form

Destiny Support is committed to providing services that are accessible to all service users regardless of race, gender or ethnicity.

The information supplied below is strictly for gathering data to monitor service provision and will remain strictly confidential.

Ethnic Origin - Please tick one box only

White	British		**Asian or Asian Briish**	Indian	
	Irish			Pakistani	
	Gypsy/Travellers			Bangladeshi	
	Other White background (Please specify)			Other Asian backrground (please specify)	
Mixed	White & Black Caribbean		**Black or Black British**	Caribbean	
	White and Black			African	
	White & Asian				
	Other mixed background (Please specify)			Other black background (please specify)	
Chinese	Chinese				
	Any other ethnic background (Please specify)				

Gender, Please tick

Male	
Female	
Transgender	

First Language

English	
Other (Please specify)	