

**Details about the Person**

<b>Title</b>	<b>First Name</b>	<b>Surname</b>
<b>Marital Status</b>	<b>Known as</b>	
<b>Address</b>	<b>Telephone No(s)</b>	
	<b>Email</b>	
<b>Date of Birth</b>	<b>Gender</b>	
<b>National Insurance No</b>	<b>Is this person a carer?</b>	
<b>Lives Alone Yes/No</b>	<b>Lives with</b>	
<b>Religion</b>	<b>Preferred Language</b>	<i>English/other (specify)</i>
<b>Ethnicity</b>	<b>Interpreter Required yes/no</b>	
<b>How does person communicate? (e.g. oral, sight, learning, representative required)</b>		
<b>Does the person use Communication aids? If so what?</b>		

<b>Relevant Medical Information (include provisional/confirmed diagnosis if known)</b>
<b>Life Threatening Medical Alert:</b> If Yes, specify

<b>Mobility include equipment / assistance</b> Please detail

<b>Reason for referral</b>

<b>Relevant Social Circumstances</b> (please make us aware of any challenging behaviours)

<b>Consent to referral</b>	
Is the person aware of this referral?	No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>
Has the person consented to this referral?	No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>
Has the person been given a leaflet on information sharing?	No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>
If No to any of above, please provide detail	

<b>GP Name</b>	
<b>Address</b>	<b>Tel no</b> <b>Fax No</b> <b>Email</b>
<b>Consultant Name</b>	
<b>Address</b>	<b>Tel No</b>

**Details about People Associated with the Person**

	<b>First Contact</b>	<b>Alternative Contact</b>
<b>Full Name</b>		
<b>Address</b>		
<b>Post Code</b>		
Tel No		
Email		
<b>Communication Issues</b>		
Relationship to person ( <i>e.g. partner, daughter etc.</i> )		
Next of kin	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Carer for Person	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Keyholder	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>

**Additional Relevant Information at Point of Referral**

**Advocacy**

Does person have an independent <b>advocate</b> ?	No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>
If yes, name & contact details	.....

**Legal/Statutory Status**

Mental Health Act	No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>
Welfare Guardian	No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>
Financial Guardian	No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>
Power of Attorney	No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>

**Risk**

<b>Adult protection/ASP</b>	Any identified issues	No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>
<b>Child protection</b>	Any identified issues	No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>
<b>Forensic</b>	Any identified issues	No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>
<b>Homeless</b>	Any identified issues	No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>
<b>Substance misuse</b>	Any identified issues	No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>
<b>Any identified risks for person referred?</b>		No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>
<b>Any identified risks for others (including staff)?</b>		No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/>
<i>If risks identified, what are they?</i>		

**Other Relevant Contacts: e.g., Care Agencies, Neighbour etc**

Service/Relationship	Contact Name	Contact Tel No

**Other Referral Information**

Preferred Response Time:	
Contact Instructions ( <i>Times/days include instructions if failure to make contact</i> )	Staying at Alternative Address
	Post code
	Telephone No

**Referrer Details**

Referral	From	To
Name		<b>Carron Alison</b>
Designation		<b>Service Manager</b>
Team		<b>Capability Scotland</b>
Address		Dumfries & Galloway Integrated Service Nithbank Bankend Road Dumfries, DG1 2SD
Email		<a href="mailto:carron.alison@capability-scotland.org.uk">carron.alison@capability-scotland.org.uk</a>
Tel No		<b>01387 244481</b>
Date of referral		
Date referral received		

**Referrer**

Signature	Date <u>  </u> / <u>  </u> / <u>  </u>
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**Decision/Action Following Referral: (for Office Use Only)**

No further action <input type="checkbox"/>	Waiting List <input type="checkbox"/>	Assessment <input type="checkbox"/>	Refer on <input type="checkbox"/> <u>  </u> / <u>  </u> / <u>  </u>
Referred by		Designation	
Specify any other services that may have been considered			
Decision / Action – Additional notes			