**ADULT SERVICES-REFERAL FORM**

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| **Person being referred information** | | | | |
| **First Name:** | | **Surname:** | | |
| **DOB:** | **Age** | **Gender** Male/Female | | |
| **Address:**  **Post Code:** | | **Dependents:**  (Children and ages) | | |
| **Contact Tel No:**  **Email address:** | | |
| **Nationality:**  **Ethnicity:** | | **Immigration Status:** UK National / EU  National / Asylum seeker / Student or working Visa / Leave to remain / No Recourse to Public Funds | | |
| **Hb STATUS**  (This is to identify if you are diagnosed with Sickle Cell or Thalassaemia or a carrier or carer) | | | | |
| **SUPPORT NEEDS / REASON FOR REFERRAL.**  (Indicate if support need is high, medium or low) | | | | |
| **Area of Support** | | **** | **Area of Support** | **** |
| DWP Benefits | |  | Engaging with community, helpful activities, reduce isolation |  |
| Social contacts, meeting others, reduce loneliness | |  | Finances/Debt |  |
| Coping strategies, peer or befriending support | |  | Healthy Lifestyles; nutrition, light physical activity, keeping well and safe |  |
| Accessing Volunteering, Employment, Training or Employment | |  | Advice, Guidance or Information |  |
| Accessing one-to-one support (Emotional wellbeing) | |  | Other agencies involved |  |
| In receipt of Direct Payments | |  | In receipt of package of care |  |
| **Other areas of support: Please state:** | | | | |
| **For Health and Social Care statutory service.** Please give any other information including risk assessment/care plan: Including other health conditions, disabilities, risk of harm to self or others, mental health. | | | | |
| **GP Details:**  **Address:**  **Telephone:** | | | | |
| **CONSENT** | | | | |
| **I hereby give my informed consent for referring agency to provide information about me and I confirm that I wish to receive support as detailed in this referral.**  **I understand any information will be held electronically and manually and will be shared with relevant person(s) to safeguard your welfare, interests and promote your well-being, support and care needs.**  **We agree to the information being held and shared as described. If you are unable to consent than we are unable to accept your referral for support.**  Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

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| **Referral Agency details:** | Name:  Agency:  Address:  Email:  Phone:  Date: |
| **Acknowledgement of Referral:** | By:  Date: |

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| **Send this form to:** | [**admin@oscarbirmingham.org.uk**](mailto:admin@oscarbirmingham.org.uk)  **or**  OSCAR Birmingham  22 Regent Place  Birmingham B1 3NJ |
| **Further Information:** | Phone: 0121 212 9209  Website: www.oscarbirmingham.org.uk |