**Complex Needs Service Referral Form**

90 Peartree Lane, Welwyn Garden City, Herts. AL7 3UL

**Tel: 01707 891120** **Email:** **cns@turning-point.co.uk**

Initial Questions

How many issues do you or your client need help with?

|  |  |  |  |
| --- | --- | --- | --- |
| Mental Health  | Yes/No | Housing | Yes/No |
| Benefits | Yes/No | Drug Misuse | Yes/No |
| Alcohol Dependency | Yes/No | Learning disability | Yes/No |
| Emotional distress | Yes/No | Linking in with services | Yes/No |
| Education/Employment/Volunteering | Yes/No | Difficulty maintaining relationships | Yes/No |

1. Do you or your client require a one off piece of work or support to help move forward? Yes/No
	* 1. If so what is the one of piece of work regarding?

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1. Names of other professional/s involvement

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1. Primary reason for referral

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| **Complex Needs Service Referral Form**90 Peartree Lane, Welwyn Garden City, Herts. AL7 3UL**Tel: 01707 891120** **Email:** **cns@turning-point.co.uk**Date Received\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Personal Details: |
| Name |  | Address: |
| Date |  |
| Gender |  |
| Date of Birth |  |
| Previously engaged with the service? | Yes |  | No |  |
| Next of Kin |  | Contact number |   |
| Sexual Orientation |  | Ethnicity |  |
| Marital Status |  | Dependants | Yes  | No  |
| Religion | Buddhist  |  | Catholic  |  | Christian  |  | Muslim  |  |
| No Religion or Belief  |  | Not Known |  | Other: |
| Employment Status: |
| Student |  | Unemployed |  | Full time employed |  | Long term sick |  |
| Other |  | Self employed |  | Part time employed |  | Short term sick |  |
| Summary of Need:  |
| Mental health |  | Physical disability |  | Finances |  |
| Drug/ alcohol use  |  | Self-harm |  | Physical health |  |
| Dual diagnosis |  | Psychological problems |  | Difficulty engaging with services |  |
| Learning disability |  | Homelessness |  | Maintaining tenancy |  |
| Offending behaviour  |  | Emotional distress |  | Difficulty maintaining relationships |  |
| Accommodation:  |
| Homeless |  | Living with family |  | Living with friends |  |
| Local Authority |  | Own Property  |  | Private Rented |  |
| Supported Housing |  | Temporary Housing |  | Not Known |  |
| Caring Role: |
| Are you a carer? Yes No (if yes, please complete below) |
| What is the risk of this caring role breaking down? HighMediumLowWould you like the service to support you with your own needs at this point in time? Yes No  |
| Referral Source: |
| Self: | Carer/Family |  |
| Service: |  | Contact Name |  |
| Onward referral: |  | Contact Number |  |
| Mental Health: |
| Diagnosis or problem |  | Medication |  |
| How long has the client experienced these problems? |  |
| CPA Level (if applicable) | Enhanced / CPA | Section 117 Yes  No  |
| Benefits status: |  | Emergency Contact: |  |
| GP Name and Surgery: |  |
| Are other services involved? | CMHT |  | Drug and Alcohol |  | Care coordinator |  |
| If so please expand; |
| What is the person’s views of their current situation |
|  |
| What support as a professional/family member / carer do you feel they need: |
|  |
| Offending Behaviour:(Any risks identified) |  |
| Does the client have a current risk assessment? Can this be sent with the referral? |  |
| Telephone referral received by CNS Staff member? |  |
| **Service user/Carer name (please circle)** |  | **Signature** |  | **Date** |  |
| **Service User has consented to service** | **Yes/No****(please circle)** | **Service User Signature** |  | **Date** |  |
| **Referrer name****(if applicable)** |  | **Signature** |  | **Date** |  |

\*Please note, if the referral form is not completed fully in all sections this could be returned to the referrer, therefore delaying the assessment process.