**Complex Needs Service Referral Form**

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

**Tel: 01707 891120** **Email:** [**cns@turning-point.co.uk**](mailto: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**](mailto: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.