1. **REFERRER DETAILS (to complete this form please click on the boxes)**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Referrer: |  | Referring organisation  Position/Title: |  |
| Tel number:  Email: |  | Date/time of referral: |  |

1. **CONSENT TO REFERRAL**

|  |  |  |  |
| --- | --- | --- | --- |
| Does the person agree to the referral to Jersey Connecting Communities? | | | Yes  No |
| Date consent was obtained: | | |  |
| How was consent obtained: | In person  On the phone  From the referrer | Witten  Verbal  Implied Consent (give reason) | |

1. **DETAILS OF PERSON BEING REFERRED**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Title: Mr /Mrs/Miss/Ms/Dr | | Gender: | F / M | | Date of birth: |  |
| Name: |  | | | | | |
| Preferred Name: |  | Mobile: | |  | | |
| Telephone: |  | Email: | |  | | |
| Preferred first language: | |  | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Address:  Postcode: | | | |
| GP/ Surgery: |  | Contact: Tel:  Email: |  |
| Reason for the referral: (Please refer to BRC criteria and reference loneliness and/or isolation) | | | |
|  | | | |
| How do you/ SU feel the Red Cross can help? | | | |
|  | | | |

|  |  |  |
| --- | --- | --- |
| If yes, has the care provider been notified of the discharge? | Y  N |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of emergency contact: |  | | Relationship to service user: |  |
| Telephone number: |  | | Do we have consent to contact them? | Y  N |
| **Living arrangement details (please tick):** | | | Is the person being referred a carer? Yes  No | Name and relationship to service user: |
| Living Alone  Living with Spouse/Partner  Living with Family/Friends  Sheltered Accommodation  Nursing/Care Home  No fixed abode  Other (specify) | | Is SU still able to support this person or is additional support required? | | |

1. **SAFETY INFORMATION**

|  |
| --- |
| **Please provide any information as to risk to British Red Cross staff.**  This could include pets, threat of violence, potential issues with other people living in the house, the safety of the area etc |
|  |

1. **COVID 19 STATUS**

|  |  |
| --- | --- |
| Does the person currently meet the COVID 19 **self-isolation** criteria?  **(is the person self-isolating)**  ***OR***  Does the person currently meet the COVID 19 **social distance** criteria?  **(is the person social distancing)** | Yes  No  Yes  No |

1. **COMMUNICATION AND MOVING AND ASSISTING**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | | **Details:** |
| Hearing | Fine |  | Limited |  |  |
| Vision | Fine |  | Limited |  |  |
| Speech | Fine |  | Impaired |  |  |

|  |  |  |
| --- | --- | --- |
| Does the person use any walking aids? | Yes  No | If yes, please detail. |
| Does the person use or require the use of a wheelchair? | Yes  No | If yes, please detail. |
| In your opinion does the person require moving and assisting support to get to and from / in and out of a BRC vehicle? | Yes  No | If yes, please detail. |
| In your opinion does the person require support to get up and down stairs safely? | Yes  No | If yes, please detail. |

1. **HEALTH & WELLBEING (ensure risk flagged on BRM)**

|  |  |
| --- | --- |
| **Does the person have any condition staff need to be aware of?** | **Details:** |
| Medical conditions |  |
| Memory issues or a Dementia diagnosis |  |
| Mental health concerns including anxiety or depression- past or present |  |
| Safeguarding concerns |  |
| Is the person able to make their own decisions or do they require support? |  |
| Behaviours that challenge |  |
| Drug or alcohol dependency-past or present  Other (please state) |  |
| **Any known risk factors?** |  |

|  |  |  |
| --- | --- | --- |
| * *Risk to self* * *Risk to staff* * *Risk of violence* * *Risk in the home* | Yes  No  Yes  No  Yes  No  Yes  No | Details: |
| **Record any of the following:** |  | |
| * *Attempted suicide* * *Self-harm* * *Self-neglect* * *Verbal abuse* * *Violence to family/others/staff* * *Anti-social behaviour* * *Inappropriate sexual behaviour* * *Drug/alcohol dependency*   *Other (please specify)* | Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No | Details: |
| **Lone working risk?**  **(based on above factors and any other reasons including risks related to the presence of third parties)**  (Ensure risk is flagged on BRM) | Yes  No | Details: |
| **Other agencies engaged?** |  |  |
| * *Social Services* * *OT/District Nurse* * *AMH* * *Community Police* * *Probation* * *Mental Health Team* * *Other (please give details) eg Housing/homeless org, Asylum/Refugee services, Drug and alcohol services, general hospital consultants/depts* | Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No | Details: |

1. **DIVERSITY INFORMATION**

|  |  |
| --- | --- |
| **Please ask the person if they would agree to answering the following questions**. We use this information to ensure that we provide inclusive services that meet the needs of the people we support. This section may be handed to the person to complete.  *(The person has the right to decline any or ALL of the questions – in this case please mark as ‘Prefer not to say’.)* | |
| **Ethnicity:** | |
| White: British  White: English  White: Jersey  White: Scottish  White: Welsh  White: Northern Irish  White: Irish  White: Gypsy or Irish Traveller  White: Other  Black: Jersey  Black: African  Black: Caribbean  Black: Other  Arab | Asian: Bangladeshi  Asian: Chinese  Asian: Indian  Asian: Pakistani  Asian: Other  Thai  Mixed: White & Asian  Mixed: White & Black African  Mixed: White & Black Caribbean  Mixed: Other  Ethnic Other (please specify):  Portuguese  Polish  **Prefer not to say** |
| **Disability/Health Issues:** | |
| Hearing impairment  Visual impairment  Physical impairment  Learning impairment  Learning difficulty (e.g., dyslexia)  **Prefer not to say** | Memory impairment  Speech impairment  Long term mental ill health  Long term medical condition  Other (please specify) |

|  |  |  |
| --- | --- | --- |
| **BRC use only - Agreed action from the referral/next steps:** | | |
| Does this referral meet the acceptance criteria? | Yes |  |
| Has this referral been accepted? | Yes |  |
| If No, Why? | |
|  | |
| BRC notes & further information: | BRC action: | |
| BRC staff: | | |