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

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Referrer: |  | Referring organisationPosition/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 presentOther (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:  |