Adults and Communities

Professional referral form to Social Care Direct

Section 1: Provider details	
Name of referrer	
Profession	
Telephone Number	
Best time to contact	
Email	
Organisation	

Section 2: Reason for Referral
Please provide brief details for your referral

Section 3: Client details			
Name of Adult			
D.O.B of Adult			
Ethnicity			
Faith			
Primary Client group	Physical Disability ☐	Mental Health ☐	HIV ☐
	Older People ☐	Older People ☐	
	Learning Disabilities ☐	Substance misuse ☐	
Address			
Telephone Number			
GP's Surgery name and address			
NOK Details			
Any known risks			
Has consent been gained to make this referral?			
Yes ☐ No ☐			

Section 4: Safeguarding

Do you have any Safeguarding concerns?	Yes ☐ No ☐ please go to Section 5

Details

Type of alleged abuse: (tick all relevant)	Physical ☐	Sexual ☐	Psychological ☐	Institutional ☐
	Neglect ☐	Financial ☐	Discriminatory ☐	
How did the abuse come to light?	Disclosure ☐	Witnessed ☐	Physical signs ☐	
	Other (please specify):			
Date of the alleged abuse:				
Location of the alleged abuse:				

Description of the alleged Abuse:

Information about the person/s causing the alleged harm

	Person 1	Person 2
Name		
Address		
Relationship to adult at risk (Relative/Carer/Etc.)		
What action has been taken so far?		

WE WILL BE CONTACTING YOU TO CREATE A SAFEGUARDING ALERT. WE MAY ASK TO PROVIDE US WITH A FIRST ACCOUNT / WITNESS STATEMENT FROM THE PERSON WHO HAS WITNESSED THE ABUSE OR HAS HAD THE INFORMATION DISCLOSED TO THEM BY AN ADULT AT RISK OR FAMILY MEMBER.

IF YOU HAVE NOT PROVIDED US WITH A MOBILE NUMBER ALREADY, PLEASE PROVIDE US WITH A MOBILE NUMBER SO THAT WE CAN GET IN CONTACT WITH YOU AS A MATTER OF URGENCY:

Section 5: Current Support		
Who does the client live with?		
Tenure: (owner occupied/rented/council property/housing association/Barnet Homes)		
Carer: (does client have any carers?) Respite? Emergency Plan/Contingency Plan		
Any current services:		Details
Domiciliary Care	☐	
Direct Payments	☐	
Day Care	☐	
Residential/Nursing	☐	
Open to other relevant services:		Details
Community District Team	☐	
Mental Health Team	☐	
Neurological Team	☐	
Learning Disabilities	☐	

Section 6: Medical	
Medical History: (medical condition) Medication and how the person manages	
Recent Hospital Admission: (date/reason)	
Sensory Impairment: (Hearing/Sight/Speech/Sensory Loss)	
Memory Impairment: (memory loss, diagnosis, concerns around mental capacity in particular areas)	

Section 7: Personal Care and Physical Wellbeing	
Does the person you are referring experiencing any difficulties in the following areas? Please provide details:	
Washing:	
Dressing:	
Using the toilet:	
Continence:	
Eating/Drinking/Nutrition:	
Skin integrity:	
Communication Needs: (Language/Interpreter required?/Speech)	

Section 8: Mobility

Does the person you are referring experiencing any difficulties in the following areas? Please provide details:	
Weight bearing status:	
Transfers (independent/assistance required/needs support/needs equipment):	
Bed:	
Toilet:	
Chair:	
Bath/Shower:	
Equipment/aids in situ:	Raised toilet seat ☐ Toilet Frame ☐ Commode ☐ Grab Rail ☐ Other (please specify)
Does the person you are referring have any difficulties accessing the community? Please provide details:	
Indoor mobility aids: (please specify)	
Outdoor mobility aids: (please specify)	

Section 9: Access to and from property

Does the person that you are referring experience any difficulties in the following areas? Please provide details:	
Negotiating Steps:	
Stairs:	
Ramp:	
Curb:	
Clutter:	
Equipment in situ:	Grab rails ☐ Ramp ☐ Step Rails ☐ Other (please specify):

Section 10: Falls

History of falls: (any falls within the last 3 months / location of fall / reason for fall)	
Pendant Alarm	Yes ☐ No ☐ Required ☐
Telecare Equipment	Yes ☐ No ☐ Required ☐

Once you have completed the form please send this to the Integrated Social Care Direct team using one of the following methods:

Phone 0208 359 5000
Email socialcaredirect@barnet.gov.uk