REFERRAL/RISK ASSESMENT FOR STOCKPORT WOMENS AID

REFERRAL FORM

2007

Part One

PERSONAL INFORMATION

NAME:	**DATE:**
DATE OF BIRTH:	**NAT. INS. NO:**
ETHNIC ORIGIN:	**CONTACT NO:**
CURRENT ADDRESS OF WHERE YOU ARE STAYING:	**ADDRESS OF WHERE YOU ARE FLEEING:**
DATE LEFT PREVIOUS ADDRESS:	
IS THE TENANCY IN YOUR OWN NAME	
Local Authority/HA Private	

NAME AND ADDRESS OF THE PERSON YOU ARE FLEEING:
YOUR RELATIONSHIP TO THIS PERSON:

NEXT OF KIN:	**IS IT OK TO USE THIS PERSON AS A POINT OF CONTACT AFTER YOU LEAVE? Y /N**
CONTACT NUMBER/S:	
ADDRESS:	
CONTACT NUMBER IN AN EMEGENCY:	

REFERRING AGENCY:	
CONTACT NAME:	**NUMBER:**
ADDRESS:	

REASON FOR REFERRAL – SPECIFY TYPE OF ABUSE (PHYSICAL, MENTAL & EMOTIONAL) AND HOW LONG HAS IT BEEN ONGOING:

AS A REFERRING AGENCY, WILL YOU BE PROVIDING ANY SUPPORT WHILST THIS WOMAN/FAMILY ARE ACCOMODATED AT S.W.A?

SALARY / INCOME

DO YOU WORK? IF YES, PART TIME OR FULL TIME?
PLACE OF EMPLOYMENT:

IF NOT, WHAT BENEFITS DO YOU RECEIVE:
REASON FOR DISSABLILITY/INCAPACITY BENEFITS:

HAVE YOU LIVED IN A REFUGE/HOSTEL BEFORE? PLEASE GIVE
DETAILS:

ADDRESS HISTORY FOR THE PAST TWO YEARS:

PREVIOUS ADDRESS:	**LANDLORD:**
	COMPANY NAME:
	ADDRESS:
POSTCODE:	
TENANCY FROM:	**POSTCODE:**
TENANCY TO:	**CONTACT NAME:**

PREVIOUS ADDRESS:	**LANDLORD:**
	COMPANY NAME:
	ADDRESS:
POSTCODE:	
TENANCY FROM:	**POSTCODE:**
TENANCY TO:	**CONTACT NAME:**

PREVIOUS ADDRESS:	**LANDLORD:**
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	ADDRESS:
POSTCODE:	
TENANCY FROM:	**POSTCODE:**
TENANCY TO:	**CONTACT NAME:**

PREVIOUS ADDRESS:	**LANDLORD:**
	COMPANY NAME:
	ADDRESS:
POSTCODE:	

TENANCY FROM:	**POSTCODE:**
TENANCY TO:	**CONTACT NAME:**

DO YOU HAVE A LOCAL CONNECTION TO STOCKPORT? EG. HAVE LIVED IN STOCKPORT:

DO YOU HAVE/OR HAVE YOU HAD ANY CONVICTIONS FOR ANY OFFENCES?

SUPPORT NEEDS

DO YOU HAVE/OR HAVE YOU HAD PROBLEMS WITH:

ALCOHOL MISUSE?
DRUG MISUSE?
VIOLENT BEHAVIOUR?
SELF HARM

MENTAL ILLNESS
GENERAL HEALTH

*** PLEASE NOTE THAT NO ALCOHOL OR ILLEGAL DRUGS ARE ALLOWED ON THE PREMISES.**

DO YOU REQUIRE ANY SUPPORT/ADVICE WITH THE ABOVE:

PLEASE GIVE DETAILS OF ANY MEDICATION YOU ARE TAKING AND ANY ALLERGIES YOU MAY HAVE:

IS THERE ANY OTHER AGENCY INVOLVED WITH YOU/YOUR FAMILY?
(EG. SOCIAL SERVICES, HEALTH VISITOR) PLEASE GIVE DETAILS:

AGENCY:	
CONTACT NAME:	**CONTACT NO:**
DETAILS:	

AGENCY:	
CONTACT NAME:	**CONTACT NO:**
DETAILS:	

AGENCY:	
CONTACT NAME:	**CONTACT NO:**
DETAILS:	

AGENCY:	
CONTACT NAME:	**CONTACT NO:**
DETAILS:	

N.B. OUR LOCAL AREA OF SOCIAL SERVICES WILL NOT ACCEPT CASE RESPONSIBILITY UNTIL YOUR CLIENT IS RE-HOUSED WITHIN THEIR AREA.

DEPENDANTS

ARE YOU PREGNANT?

DO YOU HAVE ANY CHILDREN THAT YOU WISH TO BE ACCOMODATED WITH YOU?		
NAMES	***D.O.B/AGE***	***GENDER***

DO YOU HAVE ANY PRESENTING PROBLEMS ASSOCIATED WITH THE ABOVE CHILDREN? (SPECIAL NEEDS, BEHAVIOURAL PROBLEMS ETC.)

ARE THERE ANY OTHER CHILDREN THAT ARE NOT ACCOMODATED WITH YOU?			
NAMES	**D.O.B./AGE**	**GENDER**	**REASON**

ARE ANY OF THE ABOVE CHILDREN, INCLUDING THOSE NOT BEING ACCOMODATED WITH YOU, SUBJECT TO A CARE ORDER?

DO YOU REQUIRE ASSISTANCE IN ANY AREA OF CHILDCARE?

DATA PROTECTION DECLARATION
In accordance with the Data Protection Act 1998, I agree that the agencies listed in this referral may be contacted and information shared with SWA in support of my referral, accommodation and support. Due to the health and safety implications for staff and service users of SWA, we may be unable to offer a service unless this declaration has been signed. Signature of applicant…… Date:……

Fax back to 0161 429 8756.
Any problems, call us on 0161 477 4271.

Uploaded to SWA website Oct 2007.