|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | **Community Response Referral Form** | | | | | |
| Date of Referral: | New Referral: Yes / No | | | Client Reference Number:  (Office Use Only) | | | | |
| Name of Referrer: | | | | Name of Referrer Organisation: | | | | |
| Position: | | | | Telephone No: | | | | |
| Address: | | | | E-mail address: | | | | |
| Has the original safeguarding concern been resolved? YES / NO | | | | | | | | |
| Has the client consented to referral? YES / NO  *If no, please explain why.* | | | | | | | | |
| **PERSONAL CIRCUMSTANCES OF CLIENT** | | | | | | YES | NO | Don’t Know |
| Is the person over 60 years of age? | | | | | |  |  |  |
| Does the person live in Cambridgeshire or Peterborough ? | | | | | |  |  |  |
| Does the person have an identified mental health issue or learning disability? | | | | | |  |  |  |
| Are there any risk factors? i.e. is the abuse still continuing | | | | | |  |  |  |
| |  |  | | --- | --- | | **CLIENT ETHNICITY DETAILS** | | | **Nationality** |  | | **Ethnicity** |  | | **Religion** |  | | **Sexual Orientation** |  | | **Additional Needs** |  | | | | | | | | | |
| **CLIENT CONTACT DETAILS** | | | | | | | | |
| Name:  Date of Birth: / / Age: Gender:  Address:  Marital status: | | | | Telephone:  Mobile:  **Safe to call / text / leave a message**: YES / NO | | | | |
| **DETAILS OF THE ABUSE**  **(**please include where, when, and type of abuse) Please continue on a separate sheet if necessary. | | | | | | | | |
| ***Known risk factors:*** | | | | | | | | |
| **Is the client still in an abusive situation?** YES / NO  **Is the client still in contact with the perpetrator?** YES / NO  **Perpetrator Details (if known)**:  *Name:* | | | | | | | | |
| *Relationship to Victim:* | | *Age:* | | | *Gender:* | | | |
|  | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **CIRCUMSTANCES WE NEED TO BE AWARE OF** | **YES** | **NO** | **DON’T KNOW** |
| Diagnosed major depression or anxiety, short term memory loss or dementia |  |  |  |
| Hearing Impairment |  |  |  |
| Visual Impairment |  |  |  |
| History of Falls |  |  |  |
| Housebound, poor mobility, or unable to go out alone |  |  |  |
| Does the person have an identified have any other disability such as Alzheimer’s? |  |  |  |
| Does the person live on his/her own? |  |  |  |
| Is there a history of self-harm? |  |  |  |
| If the person lives with a dependent, is that dependent considered ‘vulnerable’? |  |  |  |
| Does the person have very little contact with family members? (E.g. Once or twice a year.) |  |  |  |
| Does the person live with a family member but still feel isolated? |  |  |  |
| Does the person lack confidence to access the community on his/her own? |  |  |  |
| Is the person able to give consent to having a volunteer? |  |  |  |
| Any known substance abuse issues? |  |  |  |
| Any physical or learning disabilities? |  |  |  |
| *If answered yes to any of the above questions, please supply further information* | | | |
| **Please list all professionals/services know to be involved with person** i.e., Safeguarding, Police, Adult Social services, GP, Community Mental Health team | | | |
| **Any other Comments:** | | | |

Please return the completed form to: Community Response Team  
[southofengland@wearehourglass.org](mailto:southofengland@wearehourglass.org)