

REFERRAL FORM



There are 2 pages to this form. All sections to be completed. Any extra information can be continued on a separate sheet. Please send completed forms to contact@graceaftercare.org

AGENCY DETAILS: (only complete if you are the referring agency)	
Referrer name:	Referral agency:
Agency address:	Agency email/phone:
Why is this person involved with you service?	
Why are you referring to our service?	
Any other relevant information:	

PERSON REFERRED (or SELF): (details of person being referred)

First Name:	Address:	
Surname:		
Marital Status:	Town:	Postcode:
Age:	Date of Birth:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Home Tel:	Mobile Tel:	Email:

Emergency contact	Name:
Phone:	Relationship:

GP Name & Address:	Medication (deemed relevant):

Current issue to be supported:

CONFIDENTIAL

Contact with Mental Health Services	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Contact with ADRS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Contact with other service	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please name other service:		

RISK ASSESSMENT

	YES	NO	If YES, please describe
Mental Health Issues	<input type="checkbox"/>	<input type="checkbox"/>	
Suicide Risk/Self Harm	<input type="checkbox"/>	<input type="checkbox"/>	
Violence/Harm to Others	<input type="checkbox"/>	<input type="checkbox"/>	
Unspent Convictions	<input type="checkbox"/>	<input type="checkbox"/>	
LOR Restrictions	<input type="checkbox"/>	<input type="checkbox"/>	
Internet Restrictions	<input type="checkbox"/>	<input type="checkbox"/>	
Contact Restrictions	<input type="checkbox"/>	<input type="checkbox"/>	
Child Protection	<input type="checkbox"/>	<input type="checkbox"/>	
Other Risks Identified	<input type="checkbox"/>	<input type="checkbox"/>	
Current Social Circumstances (eg relationships, living alone, support network, homelessness)			

OTHER AGENCIES INVOLVED:

- GP Probation Social Services Hospital
 Prison Voluntary Agency AA/NA MAPPA

ETHNIC GROUP:

- White Scottish White Other British White Irish White Other
 Asian Bangladeshi Asian Chinese Asian Indian Asian Pakistani
 Asian Other Black African Black Caribbean Black Other
 Mixed Background Not Supplied Other: _____

Referrer Signature (or self): _____ **Date:** _____

Client consent to telephone/email contact (optional)

Should the referrer wish GRACE to contact them by telephone or email to arrange their first appointment, please confirm telephone number and email address to be used and obtain client signature.

Telephone number: _____ Email: _____

Client signature: _____ Date: _____