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| **REFERRAL FORM** | **Prevention, Transition and Development Service**  *Empowering residents to thrive* |

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| **WHAT DO WE OFFER?** |
| We offer a free one-to-one service supporting adults with disabilities who live in the London Borough of Hounslow to experience a greater sense of wellbeing, community, and achievement in their lives by connecting them with accessible opportunities to thrive. |
| **WHO IS ELIGIBLE?** |
| This service is for adults living in the borough of Hounslow with a disability (a physical, mental, emotional, sensory, or developmental condition which has a substantial and long-term impact on their daily life) who have consented to the service and are willing to engage. |

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| **ABOUT THE RESIDENT** | |
| Full name |  |
| Preferred name & pronouns |  |
| Date of birth |  |
| Address in Hounslow |  |
| LAS # if known |  |
| Languages |  |
| Who to contact | Resident  Parent or Carer: |
| Telephone / Email |  |

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| **SUMMARY OF NEEDS, VALUES & GOALS** |
| *What are the barriers faced by the resident and what is important to them?* |

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| **MOBILITY AND COMMUNICATION NEEDS** |
| *Does the resident need mobility or communication support to engage with this service?* |

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| **TRAVEL INDEPENDENCE** |
| *What is their level of travel independence? e.g. can they travel independently to appointments?* |

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| **LEVEL OF URGENCY & COMPLEXITY** | | | | |
| *Are there any flags that make this an urgent or complex case?* | | | | |
|  | **YES** | **NO** | **Risk Factor** | **Comment** |
| 1 |  |  | Advanced age or frailty |  |
| 2 |  |  | Mobility issues or physical disability |  |
| 3 |  |  | Presence of children in the home |  |
| 4 |  |  | Inadequate housing |  |
| 5 |  |  | Isolation / lack of support |  |
| 6 |  |  | Mental health needs (inc. hoarding) |  |
| 7 |  |  | Financial instability |  |
| 8 |  |  | Addiction or substance abuse |  |
| 9 |  |  | Medicines non-compliance |  |
| 10 |  |  | Recent trauma or crisis |  |
| 11 |  |  | Emergency service involvement |  |
| 12 |  |  | History of domestic violence |  |
| 13 |  |  | Self-harm or suicidal ideation |  |

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| **CURRENT SUPPORT INPUTS** |
| *Will you be continuing to support them? Who else is involved? Do they have supportive family?* |

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| **SUPPORT REQUESTED FROM PTD SERVICE** |
| *What specific support does the resident want from the PTD service?* |

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| **INFORMED CONSENT** |  | **SAFEGUARDING & RISK** |
| *Has the resident been involved in a conversation about this service and willingly agreed to this referral?*  **YES** |  | *Are there any known safeguarding or risk issues?* |

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| **FOR PROFESSIONAL REFERRALS** | |
| Name of referrer | [Simply paste your email signature here if it contains full details] |
| Position |
| Organisation |
| Contact information |

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| **REFERRAL DATE** |
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