



Referral

Client details:	
Name:	Date of birth
Address:	
	Gender:
Telephone:	
Is client known to the Learning Disability Service Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
Reason for Referral?	
Would the client benefit from attending a support group? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
Does the client struggle with the following:	
Healthy Relationships <input type="checkbox"/> Grooming and online safety <input type="checkbox"/>	
Domestic Abuse <input type="checkbox"/> Financial Abuse <input type="checkbox"/>	
Self Care and Esteem <input type="checkbox"/> Consent and Boundaries <input type="checkbox"/>	

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Does the client:	YES	NO	UNKNOWN
Display behaviours which challenge services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have any mental health issues/personality disorders ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have any significant medical issues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have a history or drug or alcohol addiction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a DASH form been completed with the client?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is client known to any specialist Domestic Abuse services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If 'yes' to any above please give details below			
<p>Is the client aware of this referral?</p>			
<p>Does the client have any children? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/></p>			
<p>Are the local authority involved? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/></p> <p>If 'yes', please state the stage of process:</p> <p>Please provide name and contact details of allocated social worker or family support worker?</p>			
<p>Child in need <input type="checkbox"/> Child Protection <input type="checkbox"/> Care Proceedings <input type="checkbox"/> Other <input type="checkbox"/></p>			
<p>Please give details</p>			

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Please give any information regarding the safety of the client. For example, does the perpetrator pose a risk to the client at this present time?

Referrers details

Name

Address

Telephone number

Email address

Agency

Date of referral

Date received

The information is correct and complete to the best of my knowledge and belief. I understand that Plymouth Highbury Trust and its employees cannot be held liable or responsible for any information knowingly withheld from them in respect of this client

Name

Position



Plymouth
Highbury
Trust

Please return to:

WISER

Plymouth Highbury Trust

207 Outland Road

Plymouth

PL2 3PF

01752 753719

Email: Natalie.Coady@plymouthhighburytrust.org.uk

Charity number 252156-1

Company number 05554535