**Please use this form only to refer clients to Focused Living.**

*Focused Living provides supported accommodation to people with care support and supervision needs. Dependent on individual circumstances, clients can be supported in supervisory community based shared accommodation*

Guidance and information:

* Please give clear and concise information about the client
* Please attach relevant ID & recent proof of benefits (3 months)
* Please do not leave any answers blank
* We aim to respond within 48 hours

Please be advised that in order to receive a place in our service, clients must fit the following criteria:

* Be currently in receipt of benefits
* Engaging or determined to engage with a service which addresses their support needs (eg. Local drug or alcohol services, counselling, &or other alternative services)
* Homeless or pending homelessness
* Has valid ID

*\*Please direct all referral forms to email address*

Please list any relevant documents attached to this form:

|  |
| --- |
| **Section 1:****Client Information** |
| **First Name:**  | **Surname:** |
| **Date of birth:** |  |
| **Nationality:** |  |
| **Ethnic origin:** |  |
| **Present Address:** |  |
| **Previous Address:** |  |
| **Telephone:**  |
| **Anticipated date of discharge/release if relevant:**  |
| **1.1 Referrer Details** |
| **Name of Referrer:**  |  |
| **Organisation/location:** |  |
| **Telephone:** |  |
| **Email:** |  |
| **Section 2:****Contact details** |
| **Next of Kin details**Name:Telephone:Relation to client: |
| **Hospital ward (psychiatrist or hospital consultant)*****If applicable*** Name:Organisation/Hospital:Telephone: |
| **Social Worker or Community Psychiatric Nurse** ***If applicable*** Name:Organisation:Telephone: |
| **Section Three:** **Medical & Psychiatric Details** |
| **3.1 Medical details** |
| **Has the client been diagnosed with any medical conditions?*****Please Provide details*** |  |
| **Existing related symptoms:*****Please Provide details*** |  |
| **3.2 Mental Health** |
| **Has the client been diagnosed with a mental health condition?** |  |
| **Medication on discharge/diagnosis:** |  |
| **3.3 Substance Misuse & Behavioural**  |
| **Recreational Drugs:** *Please give full details***Period of abstinence if applicable:** |  |
| **Alcohol Misuse:***Please give full details***Period of abstinence if applicable:** |  |
| **Behavioural Problems:** *Please give full details* |  |
| **Any relevant additional information:** *Please disclose any information that will be relevant to any care support and supervision provided* |  |
| **Section Four****Needs & Risk Assessments** |
| **Do you believe your clients support needs to be low, medium, or high?***Please give details* |  |
| **Social interaction****Does the client have any problems in this area?** |  |
| **Describe any problems encountered by the client with daily living activities:***E.g. cooking, cleaning, taking medication, going out, and using public transport, laundry, and shopping, budgeting, personal hygiene.* |  |
| **Risks** *Please give details of risks regarding any of the above that need to be taken into consideration:* |  |
| **4.4 Offending History**  |
| **Please provide a full offending history & risk assessment if applicable** |  |
| **Probation Details & Contact information:** |  |
| **Section Five****Benefits/Income/Banking** |
| **National Insurance Number:**  |
| **Savings (Please state the amounts)** |
| **Bank:** |  |
| **Building society:** |  |
| **Post Office:** |  |
| **Income (Please state the amount received)** |
| **Universal Credit:** |  |
| **Employment** **Support Allowance:** |  |
| **Job Seekers** **Allowance:** |  |
| **Personal Independence Payments:** |  |