**Potton Kare Services Appropriate Adult Referral**

**Please complete all sections of this form**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Please provide details of the young person being referred** | | | | | | | |
| Local Authority ID Number | Forename | Surname | DOB | Gender/Identifies as (pronoun) | Ethnicity | Religion | Language |
|  |  |  |  |  |  |  |  |

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| --- |
| **Home/Temporary Placement Address Including Postcode** |
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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Parents/carers Details (if applicable)** | | | | | |
| Relationship | Name | Contact Number | Gender/Identifies as (pronoun) | Ethnicity | Language |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

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| --- | --- | --- | --- |
| **Foster/temporary Carer Details (if applicable)** | | | |
| Relationship | Name | Contact Number | Language |
|  |  |  |  |
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| --- | --- |
| **Communication: Any Special Communication Needs?** | |
| **Yes/No (delete as appropriate)** | **If yes please provide details:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Referral Details** | | | | |
| Name of Referrer | Role of Referrer | Contact Number | Email | Name of Authorising Manager |
|  |  |  |  |  |

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| **History of Case and Current Situation/Reason for Support Being Required** |
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| --- | --- | --- |
| Days/dates required | Time required (if flexible please provide guideline – *eg, anytime between 7am-6pm*) | Length of time required\*\* |
|  |  |  |
| **Frequency (please specify, weekly, monthly, one off etc)** | | |
|  | | |

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| --- | --- | --- |
| **Risk Assessment** | | |
|  | **Y/N** | **If YES, please provide details**  ***e.g. whether this is current or historical*** |
| **Has the young person displayed any sexualised/challenging behaviour?** |  |  |
| **Has the young personshown aggression towards other children or to adults?** |  |  |
| **Are there any other risks that may be posed by the young person that the worker need to be aware of?** |  |  |

|  |  |
| --- | --- |
| **Please provide details of where invoices for this service should be sent**  **(Please note, referral will not be accepted if this section is not completed)** | |
| **Name** |  |
| **Role** |  |
| **Department** |  |
| **Email** |  |
| **Telephone number** |  |

|  |  |
| --- | --- |
| **Authorisation** | |
| **Signed (referrer)** |  |
| **Date** |  |
| **Signed (Authorizing Manager)** |  |
| **Date** |  |