



FLOATING SUPPORT REFERRAL FORM

A referral can only be accepted if it is clear that the applicant knows and agrees to be referred. Please ensure that you have fully discussed the Floating Support Service with the Client before making a referral.

Date of Referral _____

Referral Book No (Office use only) _____

Referred by _____

Contact number _____

Name of organisation _____

CLIENT DETAILS

Name: _____

Nat Ins No: _____

Current address: _____

D.O.B. _____

Telephone Number: _____

Postcode: _____

Mobile Number: _____

TYPE OF SUPPORT REQUIRED (Please indicate the type of support required by ticking all the relevant boxes)

- | | |
|---|---|
| <input type="checkbox"/> MOTIVATION/ TAKING RESPONSIBILITY | <input type="checkbox"/> PHYSICAL HEALTH |
| <input type="checkbox"/> SELF CARE AND LIVING SKILLS | <input type="checkbox"/> EMOTIONAL AND MENTAL HEALTH |
| <input type="checkbox"/> MANAGING MONEY AND PERSONAL ADMINISTRATION | <input type="checkbox"/> MEANINGFUL USE OF TIME |
| <input type="checkbox"/> SOCIAL NETWORKS AND RELATIONSHIPS | <input type="checkbox"/> MANAGING TENANCY AND ACCOMMODATION |
| <input type="checkbox"/> DRUG AND ALCOHOL MISUSE | <input type="checkbox"/> OFFENDING |

REASON FOR REFERRAL (Please note that the client may be put on a waiting list, it is therefore vital that you give as much information as possible to allow for prioritisation)

SOURCE OF INCOME

Are you employed? Yes No

Are you in receipt of benefits? Yes No

Any difficulties with claiming benefits Yes No

If yes please state which benefits

CLIENT ISSUES (Please indicate which of the following applies by ticking all the relevant boxes)

- | | |
|--|--|
| <input type="checkbox"/> Chronic health condition | <input type="checkbox"/> Parent (with children under 18) |
| <input type="checkbox"/> English is not first language | <input type="checkbox"/> Physical disability |
| <input type="checkbox"/> Homeless/temporarily housed | <input type="checkbox"/> Refugee or asylum seeker |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Sensory impairment |
| <input type="checkbox"/> Not in education, training or work (NEET) | <input type="checkbox"/> Teenage parent |
| <input type="checkbox"/> Not in work or training (adult) | <input type="checkbox"/> Victim of domestic abuse |
| | <input type="checkbox"/> Other |

RISK ASSESSMENT (Please tell us about the known risks, if any, to the applicant or to others.)

Does the person present as a risk to themselves or others Yes No

Is it recommended that this person be visited in pairs Yes No

Please provide details of suicide attempts, self-harm, violence/aggression.

OTHER SERVICES INVOLVED (Social Worker /CPN / Counsellor/ Health visitor/ Other)

Contact with other agencies? Yes No

If YES which agencies?

We will contact you to confirm acceptance of your referral. Please help to avoid delay by keeping us up to date with any changes in circumstances or contact numbers for you or the applicant.

(Office use only)

ACCEPTED

Yes No

Reason for Refusal

Date Referrer notified _____

Signed FSO _____

Please forward referral form to:

Floating Support Team
Apex Housing
10 Butcher Street
Derry / Londonderry
Northern Ireland
BT48 6HL
Telephone: +44 2871 360728
Fax: +44 2871 304801
Email: info@apexhousing.org