|  |  |
| --- | --- |
| **Date Received:** | **Office Use only** |
| **Date Acknowledged:** |  |
| **Has client given consent for referral to be made.**  | **YES NO** |
| **Section 1 – Referrer to Complete** |
| **Please note referrals will not be processed without up-to-date risk information**  |
| **Offending**  | **Y/N** | **Details** |
| Has client given consent to referral being made?  |  |  |
| Has the client been involved in the criminal justice system in the last 12 months? |  |  |
| Has the client had a caution or conditional caution in the last 12 months?  |  |  |
| Are you aware that the client has committed an offence in the last 12 months?  |  |  |
| If currently on a license, what date is this due to end? |  |
| **Support Required**  | **Please indicate with an X** |
| Complex need support (**1-1 therapeutic support Skill based DBT)**  |  |
| Peer Support and Groups(**Support around practical and social needs therapeutic groups and social groups))** |  |
| **All the above** |  |
| **If you have answered No to all of the above questions, then DO NOT refer to the Changes service.** **If you have answered YES to any of the above questions, then please continue to Section 2** |
|  |
| **Section 2 – Referrer to Complete****Please score any identified needs on a scale of 0-5. 0 being no concern. 5 being immediate risk. Please give examples to back up your score including details, frequency and nature of traits identified.** |
| **CHECKLIST FOR BEHAVIOUR INDICATIVE OF TRAUMA**  | **0-5** | **Rationale for score** |
| **Motivation and taking** **responsibility*** Low self-esteem
* Struggles to engage with support.
 |  |  |
| **Self-care and living skills.** |  |  |
| **Managing money and personal administration** |  |  |
| **Emotional and mental health*** self-harm
* Medication
* Difficulty identifying/expressing emotion and feelings.
* Misuse of emergency services (frequent presentations at A&E or ambulance call outs
* Recent suicidal ideation/attempts within last 3 months
* Recent self-injury including overdose within last 3 months.
 |  |  |
| **Problem Solving** * Does the individual struggle to problem solve.
 |  |  |
| **Social networks and relationships*** Difficulty adapting to change.
* Difficulty relating to others and maintaining relationships.
* Lacks self-identity and struggles to express needs.
 |  |  |
| **Drug and alcohol use** |  |  |
| **Physical health**  |  |  |
| **Meaningful use of time*** Impulsivity
 |  |  |
| **Managing tenancy and accommodation** |  |  |
| **Offending/Negative behaviour** * Tiggers for offending behaviour
* Anti-social behaviour
* Anger management
* Risk of harm to others
 |  |  |
| **Other*** Safeguarding issue
* social services involvement
* Reports recent abuse (within last 3 years)
* If yes score 4
 |  |  |
| **TOTAL SCORE** |  |  |
| **If you scored below 30 DO NOT refer to Changes service.** **If you scored 30 or above please CONTINUE to complete the referral form and send to the Changes Team.****If you have any queries call the team on 01924 448 975** |

|  |  |
| --- | --- |
|  **Client Details** |  |
| **Preferred Name:** |  |
| **DOB:** |  |
| **Address:****Postcode** |  |
| **Contact number(s):** |  |
| **Email address:** |  |
| **NOK / Emergency contact:****Is the client happy for this person to be contacted?** | **Yes No** |
| **Does the client have a formal Mental Health Diagnosis?** | **Yes No** |
| **Details of Mental Health Diagnosis:** |  |

|  |  |
| --- | --- |
| **Diversity and inclusion** |  |
| **Is the clients first language English?** |  **YES NO** |
| **Other language (first)** |  |
| **Will the client require an interpreter?**  |  |
| **Are there any communication issues?** |  |
| **Does the client have a learning disability?** |  |
| **Is the client autistic?** |  |
| **Does the client have memory problems?** |  |
| **Is the client ex-service personnel?** |  |
| **Does the client have any specific contact requirements?**  |  |

|  |  |
| --- | --- |
| **Referrers Details** |  |
| **Name:** |  |
| **Role and Agency:** |  |
| **Address:****Postcode** |  |
| **Contact number:** |  |
| **Email address:** |  |

|  |  |
| --- | --- |
| **Any Other Professionals Involved and Contact Number;** | **Signed Declaration – Please co-sign if referrer is not a statutory agency;** |
| **GP:** | I am in agreement with this referral; |
| **Probation:** | I am in agreement with this referral; |
| **Care Coordinator / CPN:** | I am in agreement with this referral; |
| **Other Statutory:** | I am in agreement with this referral; |
| **Voluntary Agency:** |  |
| **Other Voluntary:** |  |
|  |
| **Risk Assessment**  |
| **Dose the client have an up-to-date Risk Assessment?** |  **YES NO** |
| **Is a copy being sent with this referral?** |  **YES NO**(Please note that we are unable to process referrals without this where there is statutory involvement) |
| **Is the client subject to CPA/ MAPPA?****If YES, what is the date, time and venue of their next meeting?** |  **YES NO** |

|  |  |  |
| --- | --- | --- |
| **Ethnicity** |  | **Disability** |
| A – White - Any other white background | Yes |
| A – White - British | No |
| A – White - Irish | Client does not wish to state |
| B – Mixed – Any other mixed background | Client not asked to state  |
| B – Mixed – White and Asian |  |
| B – Mixed - White and Black African |
| B – Mixed – White and Black Caribbean |
| C – Asian or British Asian – Any other Asian background | **Gender** |
| C – Asian or British Asian – Bangladeshi | Female |
| C – Asian or British Asian – Indian | Male |
| C – Asian or British Asian – Kashmiri | Gender assigned at birth?  |
| C – Asian or British Asian – Pakistani |  **YES NO** |
| D – Black or Black British – African |
| D – Black or Black British – Any other Black background | **Sexuality** |
| D – Black or Black British - Caribbean | Heterosexual (straight) |
| E – Other Ethnic Groups – Any other Ethnic background | Gay |
| E – Other Ethnic Groups - Chinese | Lesbian |
| Client does not wish to state | Bisexual |
| Client not asked to state | Self-defined |
|  | Client does not wish to state |
| Client not asked to state |
|  |
| **Religion** | **Relationship Status** |
| Christian – All denominations | Single |
| Buddhist | Co-habiting |
| Hindu | Married |
| Jewish | Civil Partnership |
| Muslim | Other |
| Sikh | Client does not wish to state |
| No belief | Client not asked to state |
| No religion |  |
| Other – please state | **Residency** |
| Client does not wish to state | Is the client a British citizen? |
| Client not asked to state | **YES NO** |
| Other – please state |

**Please return the completed referral form and any relevant documentation as soon as possible to enable us to process the referral quickly and efficiently.**

**We aim to acknowledge receipt of referrals within 7 working days.**

**Please note: We prefer referrals to be emailed to us for processing, please ensure you save the referral form in a Password Protected document before sending. Thank you.**

**PLEASE RETURN TO:**

**EMAIL:** **changes@commlinks.co.uk**

**ADDRESS:**

**Community Links Changes Service**

**27 Trinity Street**

**Batley**

**WF17 7JZ**

**TEL: 01924 448 975**