 The Bridgeway Referral Form

Please fill form as fully as possible; any gaps please respond *Unknown* (U)

|  |  |
| --- | --- |
| **Client Details** |  |
|  |  |
| Client name |  |
| Age and DOB |  |
| AddressPostcode |  |
| Contact Details (mobile/landline/email) |  |
| Preferred method of contact  | landline mobile post email Is it safe to leave a message? Yes / No |
| Homeless / no fixed abode? |  |
| Gender | Male / Female |
|  |  |
| **Referral Agency** |  |
| Date of referral |  |
| Referrer name and contact details |  |
| Reason for referral | Sexual Violence / Sexual Abuse / Domestic Violence / Other:  |
| Has the client consented to the referral? | Yes / NoIf No why? |
| Date of most recent incident |  |
| Has it been reported to Police?  | Yes / NoName of Police Officer involved: |
|  |  |
| **Perpetrator details** |  |
| Name |  |
| Age and DOB |  |
| Relationship to client |  |
| Address if known |  |
| Gender | Male / Female |
|  |  |
| **Dependants** |  |
| Are there any children who have contact with or live with the client?  | Yes / No |
| Name of child/childrenAges and DOB |  |
| Name of school |  |
| Is the child/children subject to: | Early Help LAC Section 17 Section 47 |
| Name and contact details of Social Worker if applicable |  |
| Are there any vulnerable adults who live with or have contact with the client?  | Yes / No |
| Name of vulnerable adult/s |  |
| Age and DOB |  |

**Mental Health Concerns / History**

|  |  |
| --- | --- |
| Any current mental health issues?  | Yes / No |
| Any previous mental health issues?  | Yes / No |
| Any self-harm / self-injuries?  | Yes / No Details and date of most recent  |
| Suicidal ideation?  | Yes / NoDetails |
| Suicide attempts?  | Yes / No accidental / deliberateDetails and date of last attempt |

**Health**

|  |  |
| --- | --- |
| Is the client on any medication?  | Yes / NoName and daily amount |
| Alcohol Misuse? | Yes / NoDetails of type and daily amount |
| Drug Misuse?  | Yes / NoName, amount and how used |
| Physical disability / illness? | Yes / NoDetails |
| Learning Disability?  | Yes /NoDetails |
| Could the client be pregnant?  | Yes / NoIf yes, how far on? |
| Is the client in need of sexual health services?  | Yes / No |

**Other**

|  |  |
| --- | --- |
| Is client at risk of domestic violence at home?  | Yes /No |
| Is client at risk of sexual violence at home?  | Yes / No |
| Is client at risk of stalking or harassment?  | Yes /No |
| Is client at risk of trafficking or sexual exploitation?  | Yes / No |
| Is client at risk of honour based violence or forced marriage?  | Yes / No |
| Is the client engaging in prostitution?   | Yes / No |
| Are there any other risk issues that the client is aware of?  | Yes / NoDetails |

Name of GP:

GP Address:

Details of other agencies involved or referrals have been made to including:

Early Help / MARAC / Children’s Services

Agency:

Contact Name:

Contact Number:

Date of Referral:

Outcome:

Action taken ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Signature……………………………………………

Date ………………………………

Please send this form via either of the following ways:

Fax:  01768 892527

Email: Donna.Cardell@uk.g4s.com or Carrie.Atkinson@uk.g4s.com

Once referral has been sent please call 01768 800670 / 01768 800671 to confirm receipt