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**Community Connect Referral Form**

**Please return form when completed to**

**communityconnect@curo-group.co.uk**

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| **Date of Referral Received:** **Referral recorded by:** |  | **Community Connect Officer** **(who will deal with the case):**  |
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| **Referrer’s Details:** |  |
| Referrer’s Name: |  |
| Referrer’s Telephone Number and / or e-mail Address: |  |
| Referrer’s Relationship to Customer:*(e.g. relative, neighbour, Social Worker)* |   |
| How did you hear about our Community Connect Service?*(e.g. leaflet in Library, GP Surgery)* |  |

**Customer’s Details:**

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| Is the customer you are referring to us aware of this referral being made?Yes [ ]  No [ ] If No, please obtain consent from the customer as we will be unable to proceed with this referral |

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| Customer Name: | Address:  | Telephone Number / E-mail Address (if applicable): |
| Date of Birth:  | Gender: (Male/Female/Transgender): | Sexual Orientation: *(Heterosexual, Homosexual, Bisexual, Lesbian)* |
| Marriage/Civil Partnership Status:*(married, widowed, partnership, civil partnership, divorced, single, separated, prefer not to say)* | Religion / Belief:*(Christian (all denominations), Buddhist, Hindu, Jewish, Muslim, Sikh, Any Other Religion)* | Ethnicity:  |

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| **Carer:**Is the customer a carer? Yes [ ]  No [ ] **If yes, carer to whom?**  |

**Reason for calling / referral:**

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| **Isolation and Loneliness Assessment Tool** |
| Think about whether the customer is: | ✓ / 🗶 | If they are consider: |
| Emotionally isolated? |  | 1-2-1 contact |
| Physically isolated? |  | Groups |
| Socially isolated? |  | 1-2-1 and groups |
| Lonely? |  | Intensive support (Connect Plan) |

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| Does the customer consider themselves disabled? Yes [ ]  No [ ]  |

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| Does the customer have any mobility issues? Yes [ ]  No [ ] If Yes, what walking aids do they use to help mobilise inside and outside the property?*(e.g. walking stick, frame, wheeled walker):* Is customer a wheelchair user?Yes [ ]  No [ ] If Yes, is the wheelchair manual or electric?  |

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| **Health Issues/Medical Conditions: (Physical and Mental Health):**If known, please advise of any medical conditions the customer has – chronic or acute: |

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| **Dementia/Alzheimer’s** Does the customer have a diagnosis of Dementia?Yes [ ]  No [ ]  If no, are there any concerns over memory  Yes [ ]  No [ ] If yes, please provide examples of behaviour that may be indicative of undiagnosed dementia: |
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| **GP Surgery:**  | **GP Surgery Tel No:**  |

**Risk Assessment**

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| **Access and condition to Property** |
| **Questions**  | **Response** |
| What information do we need to be made aware of regarding accessing to the property? (e.g. stairs or hoarder) | **Yes** | **No** |
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| Will anyone else be at the property when I visit? | **Yes** | **No** |
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| Does anyone smoke indoors at the property? | **Yes** | **No** |
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| Are there pets in the household?  | **Yes** | **No** |
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| **Higher risks that have been flagged** **Could include:** alcohol or substance misuse, aggressive or violent behaviour, history of complaints from another organisation or well-being worker?  |
| Is there anything to report, if yes please make comment below | **Yes**  | **No**  |
| **Free text** |

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| **Result of the call / referral.**  |