Capability Scotland Dumfries & Galloway Integrated Service Referral Form

Details about the Person

Title **First Name** **Surname**	
Marital Status	**Known as**
Address	**Telephone No(s)**
	Email
Date of Birth	**Gender**
National Insurance No	**Is this person a carer?**
Lives Alone Yes/No	**Lives with**
Religion	**Preferred Language** ***English/other (specify)*** **Interpreter Required yes/no**
Ethnicity	
How does person communicate? (*e.g. oral, sight, learning, representative required*) **Does the person use Communication aids? If so what?**	

Relevant Medical Information *(include provisional/confirmed diagnosis if known)*
Life Threatening Medical Alert: If Yes, specify

Mobility include equipment / assistance **Please detail**

Reason for referral
Relevant Social Circumstances
(please make us aware of any challenging behaviours)

Consent to referral

Is the person aware of this referral?	No ☐ Yes ☐ Don't Know ☐
Has the person consented to this referral?	No ☐ Yes ☐ Don't Know ☐
Has the person been given a leaflet on information sharing?	No ☐ Yes ☐ Don't Know ☐
If No to any of above, please provide detail	

GP Name	
Address	**Tel no** **Fax No** **Email**
Consultant Name	
Address	 **Tel No**

Details about People Associated with the Person

	First Contact	Alternative Contact
Full Name		
Address		
Post Code		
Tel No		
Email		
Communication Issues		
Relationship to person *(e.g. partner, daughter etc.)*		
Next of kin	No ☐ Yes ☐	No ☐ Yes ☐
Carer for Person	No ☐ Yes ☐	No ☐ Yes ☐
Keyholder	No ☐ Yes ☐	No ☐ Yes ☐

Additional Relevant Information at Point of Referral

Advocacy

Does person have an independent **advocate?**	No ☐ Yes ☐ Don't Know ☐
If yes, name & contact details	……

Legal/Statutory Status

Mental Health Act	No ☐ Yes ☐ Don't Know ☐
Welfare Guardian	No ☐ Yes ☐ Don't Know ☐
Financial Guardian	No ☐ Yes ☐ Don't Know ☐
Power of Attorney	No ☐ Yes ☐ Don't Know ☐

Risk

Adult protection/ASP	Any identified issues	No ☐ Yes ☐ Don't Know ☐
Child protection	Any identified issues	No ☐ Yes ☐ Don't Know ☐
Forensic	Any identified issues	No ☐ Yes ☐ Don't Know ☐
Homeless	Any identified issues	No ☐ Yes ☐ Don't Know ☐
Substance misuse	Any identified issues	No ☐ Yes ☐ Don't Know ☐
Any identified risks for person referred?		No ☐ Yes ☐ Don't Know ☐
Any identified risks for others (including staff)?		No ☐ Yes ☐ Don't Know ☐
If risks identified, what are they?		

Other Relevant Contacts: ***e.g., Care Agencies, Neighbour etc***

Service/Relationship	Contact Name	Contact Tel No

Other Referral Information

Preferred Response Time:	
Contact Instructions *(Times/days include instructions if failure to make contact)*	Staying at Alternative Address Post code
	Telephone No

Referrer Details

Referral	From	To
Name		**Carron Alison**
Designation		**Service Manager**
Team		**Capability Scotland**
Address		Dumfries & Galloway Integrated Service Nithbank Bankend Road Dumfries, DG1 2SD
Email		**carron.alison@capability-scotland.org.uk**
Tel No		**01387 244481**
Date of referral		
Date referral received		

Referrer

Signature	**Date** __/__/__

Decision/Action Following Referral: (*for Office Use Only*)

No further action ☐	Waiting List ☐	Assessment ☐	Refer on ☐ __/__/__
Referred by		Designation	
Specify any other services that may have been considered			
Decision / Action – Additional notes			