Referral Form – RN/RM Veterans Outreach

Client Information:

Full Name:	
Address:	
Postcode:	
Tel No:	
Email Address:	
Gender:	
Date of Birth:	
Marital Status:	
Service Number:	
Dates of Service – From:	To:

I confirm I am aged 55 or over ☐

I confirm I am in receipt of a full service pension ☐

Preferred method of contact (Please tick all that apply):

Telephone ☐	Text ☐	Email ☐

Other people in household

Name	Gender	DOB (if under 18)	Relationship to client
Pets:			

Key Contacts	Contact Details	Do we have permission to contact them?
G.P.		
Other		

Support Required:

(Please tick relevant boxes)		
Housing	Yes ☐	No ☐
Mental Health	Yes ☐	No ☐
Financial Advice	Yes ☐	No ☐
Access to specialist services	Yes ☐	No ☐
Substance misuse	Yes ☐	No ☐
Social isolation	Yes ☐	No ☐

Any other information to support the referral:

Background Information

Please attach any existing assessment information which may be relevant to this referral and indicate which information has been provided			
CPA Care Plan	☐	Adult services	☐
CMHT Assessment	☐	Other	☐

Risk Management

Is there a current Risk Assessment available (if YES please attach)	Yes ☐	No ☐
Are there any concerns to indicate immediate risk to self or others?	Yes ☐	No ☐
If YES, please provide details		
Are there any concerns about potential risk, ie environment	Yes ☐	No ☐
If Yes, please provide details		

Referrer information:

Name of Referrer:		
Address:		
Postcode:		
Tel No:		
Agency/organization:		
Nature of involvement with applicant:		
How long have you known the applicant?		
Do you visit the applicant in their own home?	Yes ☐	No ☐
Do you believe the applicant poses a risk to themselves or to others?	Yes ☐	No ☐
If yes, please provide details:		
Are you aware of other agencies involved with the applicant? Please give details:		
Reasons for application? Please give as much details as possible.		
I confirm that I have discussed the Alabaré RN/RM Outreach Service with my client and have their permission to submit this referral.		
Signature:	Date:	

Equal Opportunity Monitoring

Ethnic background (Please Tick)

A) White British: ☐ Irish: ☐ Other: ☐

B) Mixed White & Black Caribbean: ☐ White & Black African: ☐ White & Black Asian: ☐

Other: ☐

C) Asian or Asian British Indian: ☐ Pakistani: ☐ Bangladeshi: ☐ Other: ☐

D) Black or Black British Caribbean: ☐ African: ☐ Other: ☐

E) Chinese or other ethnic group Chinese: ☐ Other: ☐

F) Gypsy, Romany, Irish Traveller ☐

G) Declined ☐

Does the client have any disabilities as follows:

a) **Mobility** ☐
b) **Visual impairment** ☐
c) **Hearing impairment** ☐
d) **Progressive disability/chronic illness** ☐
e) **Learning disability** ☐
f) **Other** ☐
g) **Declined** ☐

Client's religion?

a) **None** ☐
b) **Christian (all denominations)** ☐
c) **Buddhist** ☐
d) **Hindu** ☐
e) **Jewish** ☐
f) **Muslim** ☐
g) **Sikh** ☐
h) **Any other religion** ☐
i) **Declined** ☐

Once completed, please send this form to:

Alabaré
Riverside House
2 Watt Road
Salisbury
Wiltshire SP2 7UD

Alternatively email to: veterans@alabare.co.uk

Please remember to attach the required background information

Under the Data Protection Act 1998, the information about you on this form will remain confidential to Alabaré and will only be passed to third parties if required for legal or statutory purposes.