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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Independent Visitor**  ***-*** *Referral Form* | | | ACT_Logo_CMYKACT_Logo_CMYKACT_Logo_CMYKACT_Logo_CMYK | | |  | |
|  | | | | | | | |
| ***Referring Agency Details*** | | | | | | | |
|  | |  | | | | | |
| Referring Agency | |  | | | | | |
| Telephone Number | |  | | | | | |
| Email | |  | | | | | |
| Name of Contact | |  | | | | | |
|  | |  | | | | | |
| ***Young Person’s Details*** | | | | | | | |
|  | | | | | | | |
| First Name | |  | | | | | |
| Last Name | |  | | | | | |
| Carer/Guardian Full Name | |  | | | | | |
| Address | |  | | | | | |
|  | |  | | | | | |
| Postcode | |  | | | | | |
| Contact Telephone Numbers | |  | | | | | |
| Date of Birth | |  | | | | | |
| Ethnic Origin | |  | | | | | |
| Gender | |  | | | | | |
| Known Disability | |  | | | | | |
| Social Worker | |  | | | | | |
| Contact Details | |  | | | | | |
|  | |  | | | | | |
|  | |  | | | | | |
| *Interests and needs*  To enable us to best match this individual, please add in any interests or strengths they have. Also include if there is a preference of gender of the IV. | | | | | | | |
| |  | | --- | |  | |  | |  | | | | | | | | |
| *Additional Information* | | | | | | | |
| To enable us to best support this individual please advise of any additional or specific support needs, including current issues, which may impact on the individual. | | | | | | | |
|  | | | | | | | |
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|  | | | | | | | |
|  | | | | | | | |
| Signed: |  | | | Date: |  | | |
|  | | | | | | | |
| **CONFIDENTIALITY** *(to be completed by the Service User prior to referral)*  I understand that the Referring Agency and Anglia Care Trust will exchange such information as necessary for the purpose of this referral. | | | | | | | |
| Signed: |  | | | Date: |  | |  |
|  | | | | | | | |
|  | | | | | | | |
| **Completed referrals should be sent to:**  Anglia Care Trust, Unit 8, The Square, Martlesham, Ipswich, Suffolk, IP5 3SL  Tel: 01473 622888 Fax: 01473 618660 Email: admin@angliacaretrust.org.uk | | | | | | | |

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| --- | --- | --- | --- |
| ***Independent Visiting risk assessment***  ***To be completed by Referrer*** | |  |  |
|  |  | | |

|  |  |  |
| --- | --- | --- |
| REFERRER: | | DATE: |
| SERVICE USER: | | DOB: |
| **Please provide any relevant information to assist us in preparing a Risk Assessment** | | |
| OFFENDING BEHAVIOUR |  | |
| SEXUAL |  | |
| SUBSTANCE MISUSE |  | |
| PHYSICAL & MENTAL HEALTH |  | |
| VIOLENCE & AGGRESSION |  | |
| ASSOCIATES |  | |
| OTHER – PLEASE DETAIL |  | |

**Please complete and send to admin@angliacaretrust.org.uk**