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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.  |
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| *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 3SLTel: 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**