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| **Referral form to Live at Ease**  \*\*Please complete both pages in full\*\* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **REFERRER** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date: | | | | | | |  | | | | | | | | | |
| Organisation/service: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PERSONAL DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | DoB: | | | | |  | | | | | | | | | | |
| Address: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | Post Code: | | | | | | | | | |  | | | | | | | | | NINO: | | | | |  | | | | | | | | | | |
| Tel No: | |  | | | | | | | | | | | | | | | Email: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Any Safeguarding or Risks/Triggers: | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Any language/communication barriers: | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please indicate below for each question with an X in the box** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Does the person have any kind of disability, including, physical, mental health, learning difficulties, brain injury, sensory impairment, autism? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | |  | | | NO | |  | | |
| Physical | | | |  | | | | | Mental Health | | | | | | |  | | | | Brain Injury | | | | | | | | |  | | ADHD | | | | | | | | |  | | | | Autism | | | | | | |  | |
| Sensory | | | | | | |  | | | | Learning Difficulties | | | | | | | | | | |  | | | | | Other: | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Has the person served in the Armed Forces? (Enter details below) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | |  | | | NO | |  | | |
| Is the person a dependent/partner of an Armed Forces Veteran? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | |  | | | NO | |  | | |
| Is the person engaged with any support services/groups? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | |  | | | NO | |  | | |
| Does the person feel isolated/socially excluded due to their disability and/or mental health difficulties? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | |  | | | NO | |  | | |
| Is the person at risk of homelessness? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | |  | | | NO | |  | | |
| Does the person have any priority urgent needs within 7 days? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | |  | | | NO | |  | | |
| **If URGENT, please state what:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Person’s military service details** (indicate below with an X in the box) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Royal Navy | | | | | |  | | Army | | | | | |  | RAF | | | |  | | | | | Royal Marines | | | | | |  | |  | Regular | | | | | | | |  | | | | | | Reserve | | | | |  |
| Service Number: | | | | | | | | | |  | | | | | | | | | | | | | | | Dates of service (years); | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| Ship, Regt, Trade, Unit: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Consent (indicate with an X as appropriate)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Does the person consent to you referring them to Disability Stockport? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | | | |  | | | NO | |  | |
| Have you told the person we will send them a text or email to confirm they have been referred to us and the importance they answer when we ring them? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | |  | |

Please complete page 2 with as much relevant information as you can regards their situation, and if they are getting any current support, so we do not duplicate.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please indicate below help/support required with an X in the box** | | | | | | | | | | | | | | | | | |
| Wellbeing |  | | Homelessness | | |  | | Debt |  | Benefits | | |  | Welfare |  | Isolation |  |
| Counselling | |  | | Support |  | | Employability | | | |  | Other - | | | | |  |
| **GIVE A BRIEF Outline of Identified Issue/s Or Support Required** | | | | | | | | | | | | | | | | | |
| **\*\*Please provide a brief outline of issues, support/help they require, and what information, advice and/or support you gave them so far**. Any key dates or timeframes for benefits or housing issues**\*\***  **Attach their proof of their military service with your referral if you have it.** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Advice, Information and/or Support given so far by you?** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| By sending this referral form you confirm that the person you’re referring has provided verbal consent for Disability Stockport to hold their name and contact telephone number for the purpose of contacting them, and if required to for us to discuss/act on their behalf if required with their Council’s Revenue & Benefits team, DWP, their social or private landlord, GMP, and Adult Services. | | | | | | | | | | | | | | | | | |
| Please send the completed referral to Gavin Jones (Veteran Services Manager) on; [gavin.jones@disabilitystockport.org.uk](mailto:gavin.jones@disabilitystockport.org.uk?subject=Referral) | | | | | | | | | | | | | | | | | |