**Adult Services - Programme Referral Form**

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| **Referrer’s Details** | **To be completed by Referrer** **All sections must be completed** |
| Programme referring to: |  |
| Name of and post held by Referrer: |  |
| Referrer’s contact details:  | Email address:Mobile Tel No.:  |
| Date of Referral: |  |
| **Client’s Details** | **To be completed by Referrer**  |
| First Name: |  |
| Surname: |  |
| Title: | Mr Mrs Miss Ms Other |
| Address: |  |
| Post Code: |  |
| Phone Number: | Landline:Mobile: |
| Email address: |  |
| D.O.B: |  |
| Please log any known Disabilities or Medical Issues: |  |
| Name and address of GP: |  |
| Emergency Contact Name and Number: |  |
| Dietary requirements |  |
| Ethnicity (please tick): | White-British White-Irish White-OtherMixed-White and Black CaribbeanMixed-White and Black AfricanMixed-White and Asian Mixed-OtherIndian Pakistani Bangladeshi Asian-Other Caribbean African Black-OtherChinese Other Not Stated Not known |
| Religion (if known): |  |
| Gender: | Female Male Gender Diverse |
| Sexual Orientation (if known): | Heterosexual/Straight Gay LesbianBisexual Unsure  |
| Employment Status:  | Employed – Full time Employed – Part timeUnemployed (eligible for benefits) Unemployed (not eligible for benefit’s) Student – Full time Student – Part time |
| Relationship Status: |  |
| Have they ever served in the Armed Forces?  | Yes No Not known |
| Are they a carer? | Yes No Not known |
| Details of Social Worker and/or other Professionals involved: |  |
| Known risk factors (previous convictions): |  |
| Is the participant a parent/guardian or currently pregnant: | Yes No Not known |
| Child(rens) name(s); Date(s) Of Birth(s); School they currently attended | NameDOBSchoolName DOBSchoolNameDOBSchool |
| Who does the child(ren) live with:Address(es): |  |
| Is the child(ren) on any plans: (i.e CIN, CP, PLO) |  |
| Partner/Ex-partner details:(Name; Address; Risk Factors; Convictions) |  |
| Reason for Referral: |  |
| **Thank you for the information provided. The Referral will now be processed and a member of the DVA team at RCT will contact the individual you have referred shortly to plan appropriate interventions.****For completion by RCT staff only** |

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| **RCT Information** | **To be completed by RCT DVA Admin staff**  |
| Date Referral received into RCT: |  |
| Processed by (Staff Name): |  |
| Date Referral uploaded onto Lamplight: |  |
| Date Referral passed to DVA Lead and Admin Signature: | Date: Signature: |
| **RCT Information** | **To be completed by RCT DVA Lead** |
| Date Received by DVA Lead: |  |
| Name and job title of Key Worker assigned by DVA Lead:  | Name:Job Title:DVA Lead Signature: |
| **RCT Information** | **To be completed by allocated Key Worker** |
| Date Received by Key Worker: |  |
| Client contacted by Key Worker via telephone (date & time): | Date:Time: |
| Initial meeting arranged with Client by Key Worker: | Date:Time:Location: |
| Date contact details uploaded onto Lamplight by Key Worker: | Date:Signature: |
| Notes/Additional Information: |  |

**1. Continuing Service Requirements**

**An exit strategy should set forth the Organisation’s service requirements for the period during which the parties are transitioning out of the relationship. These requirements may include:**

* **An obligation by the supplier to continue performing the services at the same level of quality for the transition period and to continue to comply with all the obligations in the contract.**
* **Requirements for the provision of parallel services for a certain period, with the right to extend the term as necessary to resolve issues before the final cutover.**
* **An obligation by the supplier to keep the same supplier team performing services during the transition period.**
* **Confidentiality on any communications regarding the termination of the relationship.**

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