**Tameside Women & Families Centre**

**REFERRAL FORM**

**Introduction and guidance**

The Women and their Families centre is a service provided by Jigsaw Support (part of Jigsaw Homes Group) and commissioned by Tameside Metropolitan Borough Council. Located at Cavendish Mill, Bank Street Ashton-under-Lyne, OL6 7DN the service provides access to 1:1 support and access to group sessions to help users overcome barriers and challenges they face.

**Consent and privacy notice**

If you are making a referral for someone else please ensure;

* You are familiar with the eligibility requirements
* You have the consent from the client to share their information with us
* You and the client are aware of and how to access our privacy notice <https://www.jigsawhomes.org.uk/privacy-policy/>

**Eligibility**

Women aged 18 years or over and their families that require support in relation to one or more of the following areas;

* + Access to support for domestic abuse
	+ Substance misuse
	+ Mental health
	+ Physical health
	+ Parenting skills
	+ Criminal justice issues
	+ Engagement with other agencies
	+ Housing
	+ Debt and financial
	+ Life skills
	+ Education and training
	+ Volunteering and employment
	+ Support to access groups and networks in relation to any of the areas listed above

**Completing the referral**

To access the service a referral form must be completed by/for the client. This referral form can be used to self-refer or by a referring agent.

Please complete all relevant questions of this referral form. If you require support completing this form, to check eligibility or for more information please email WomensCentre@jigsawhomes.org.uk or telephone 0161 331 2211

You will receive an automated confirmation email and your referral will be processed within 5 working days.

**All completed referrals should be emailed to** **WomensCentre@JigsawHomes.org.uk**

**Section 1: Details of Referring Agent (all)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of referral** | / / | **Referral source** | [ ]  Self-referral | [ ]  Agent |
| **Move to section 2 if this is a self-referral** |
| **Agency/organisation name** |  |
| **Contact name** |  |
| **Contact number/email** |  |
| **Mandatory attendance**Is this person required to engage with the service by probation or another similar service? | [ ]  Yes  | [ ]  No  | If ‘Yes’ please give details, who requires their attendance and why |
|  |

**Section 2: Client Details (all) *All fields are Mandatory***

|  |  |  |  |
| --- | --- | --- | --- |
| **First name** |  | **Surname** |  |
| **DOB** |  | **NI No.** |  |
| **Contact number** |  |
| **Email** |  |
| **Area/Postcode** |  |
| **Pregnant**[ ]  Prefer not to say | [ ]  Yes  | [ ]  No  | If ‘Yes’ please give any other relevant details |
|  |
| EDD |  / / |
| **Disability**[ ]  Prefer not to say | [ ]  Yes  | [ ]  No | If ‘Yes’ please specify |
| [ ]  Physical | [ ]  Learning | [ ]  Mental health | [ ]  Multiple impairments |
| **Ethnicity**[ ]  Prefer not to say | [ ]  White[ ]  White British[ ]  White Irish[ ]  White Other | [ ]  Black British [ ]  Black African[ ]  Black Caribbean[ ]  Black Other | [ ]  Asian Bangladeshi[ ]  Asian Pakistani[ ]  Asian Indian [ ]  Asian Other  | [ ]  Mixed race[ ]  Other |
| If ‘other’ please specify |  |
| **Sexuality**[ ]  Prefer not to say | [ ]  Heterosexual[ ]  Bisexual[ ]  Lesbian [ ]  Pansexual [ ]  Other |
| If ‘other’ please specify |  |
| **Gender**[ ]  Prefer not to say | [ ]  Female[ ]  Transgender[ ]  Other |
| If ‘other’ please specify |  |
| **Safe contact arrangements**Does this person have additional contact arrangements for their safety? | [ ]  Yes  | [ ]  No  | If ‘Yes’ please give details |
|  |
| **Assessment requirements**Does this person have additional assessment requirements? Such as needing an interpreter | [ ]  Yes  | [ ]  No  | If ‘Yes’ please give details |
|  |
| **Have you accessed the service before?** | [ ]  Yes | [ ]  No | If ‘Yes’ approximately when did the service end | **Month / Year** |

**Section 3: Any children Information (all)**

**Abbreviations:** CP – Child Protection, CIN - Child in Need -, PLO – Public Law Outline, CO – Care Order

|  |
| --- |
| **Provide details of all children and who they live with** |
| **Name** | **Living with** | **Sex** | **DOB** | **School** | **Subject to** |
|  |  |  |  |  | [ ]  CP  | [ ]  CIN  |
| [ ]  PLO  | [ ]  CO |
| [ ]  Other |
|  |  |  |  |  | [ ]  CP  | [ ]  CIN  |
| [ ]  PLO  | [ ]  CO |
| [ ]  Other |
|  |  |  |  |  | [ ]  CP  | [ ]  CIN  |
| [ ]  PLO  | [ ]  CO |
| [ ]  Other  |
|  |  |  |  |  | [ ]  CP  | [ ]  CIN  |
| [ ]  PLO  | [ ]  CO |
| [ ]  Other  |

**Section 3: Safeguarding (all)**

|  |  |  |
| --- | --- | --- |
| **Do you believe that there are risks facing the children in the family?** | [ ]  Yes  | [ ]  No  |
| **Has a referral been made to safeguard the children?** | [ ]  Yes  | [ ]  No  |
| **Are the family known to Children’s Social Care?** | [ ]  CP  | [ ]  CIN  |
| [ ]  CAFF  | [ ]  TFT  |

**Abbreviations:** CAFF - , TFT -

**Section 4: Support Needs (Referring Agent only – Self referral do not complete)**

|  |  |  |
| --- | --- | --- |
| **Support areas** | **Y/N** | **Please provide brief information of the current situation and what support is required** |
| **Domestic Abuse**  |  |  |
| **Substance misuse**  |  |  |
| **Mental health Issues** |  |  |
| **Physical health Issues** |  |  |
| **Parenting**  |  |  |
| **Criminal justice issues**  |  |  |
| **Engagement with other agencies**  |  |  |
| **Housing** |  |  |
| **Debt and financial** |  |  |
| **Life skills (language/ living skills)**  |  |  |
| **Employment, Education, training** |  |  |

**Section 5: Safety Plan (Referring Agent only – Self referral skip to Brief Assessment to complete with staff)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Safety Factor** | **Score**Bottom of page | **Details**Please provide details and context in relation to factors scored **1, 2 or 3** including history, triggers and effects on the person | **Actions** Please provide details of any support or actions for factors scored **1, 2 or 3**.if there is no support or control in place please write ‘None’ |
| **Self-Harm/Suicidal Thoughts/Attempts** |  |  |  |
| **Alcohol/Drug** **Use/Other** |  |  |  |
| **Physical Health/Disability** |  |  |  |
| **Offending Behaviours Against the Person** |  |  |  |
| **Other Offending Behaviours** |  |  |  |
| **Housing & Neighbourhood** |  |  |  |
| **Child Protection** |  |  |  |
| **Mental Health, including Anxiety & Depression** |  |  |  |
| **Risks from and/or to Others** |  |  |  |
| **Lone Working** |  |  |  |
| **Total Score** |  | (Please add together all of the scores and put the total score in this box)

|  |
| --- |
| **Safety Scale Scores** |
| **1 - Very High** | Current issues concerns having extreme impact on wellbeing/safety of self and/or others |
| **2 - High** | Current issues/concerns not being addressed/managed |
| **3 - Med** | Current issues/concerns being addressed/managed |
| **4 - Low** | Historical issues over 2 years ago |
| **5 - None** | No issues or concerns |

 |

**Declaration:** I agree that the information in this form is true and accurate to the best of my knowledge. If I have completed this form on behalf of someone else that I have consent from the client named in Section 2 to disclose this information.

|  |  |
| --- | --- |
| **Full name** |  |
| **Signature** |  |
| **Date** |  / / |

Where signed on behalf of client state relationship i.e. referring agent, family member

|  |  |
| --- | --- |
| **Relationship to client** |  |

**INTERNAL USE ONLY**

|  |  |  |
| --- | --- | --- |
| **Referral Accepted** | [ ]  Accepted for brief assessment[ ]  Accepted for full assessment | [ ]  Accepted for access to groups |
| If ‘Accepted - Other’ please give details below |
|  |
| **Reason for not engaging**  | [ ]  Eligibility[ ]  Insufficient detail | [ ]  Withdrawn[ ]  Other |
| If ‘Other’ please give details below |
|  |

|  |  |  |
| --- | --- | --- |
| **Action(s) taken** | [ ]  Brief intervention [ ]  Support [ ]  Other action | [ ]  Advice given[ ]  Signposted |
| Please give details the action(s) taken |
|  |

|  |  |  |
| --- | --- | --- |
| **Referral processed by** | [ ]  Staff | [ ]  Volunteer |
| **Name** |  |
| **Contact number/email** |  |
| **Date processed** |  / /  |

**All completed referrals should be emailed to** **WomensCentre@JigsawHomes.org.uk**