

STF Hub, Borough Road, St Helens, WA10 3RN  
Tel: Email: referrals@standingtallfoundation.org.uk

**To ensure the referral is sent to the correct team could you please tick which help is needed for the person/s you are referring:**

**Mental Health  Addiction  Housing/Benefits **

**Initial Referral Form (CONFIDENTIAL)**

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| 1. Details of referred person | | | | | | | |
| Surname: | | | | | | Forename(s): | |
| Address or C/O: | | | | | | | |
| Date of Birth: | | | National Insurance No: | | | | |
| Home Telephone No: | | | | | Mobile No: | | |
| Date / / | | | | | | | |
| Is the client a | Social  Tenant 🞏 | Private Tenant 🞏 | | Homeless🞏 | | | Homeowner 🞏 Other 🞏  Please state: |
| G.P Details: | | | | | | | |
| Name of Landlord if known: | | | | | | | |

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| 2. Reason for Referral |
| Please explain what difficulties they are having at the moment and why you are referring them to The Standing Tall Foundation   |  |  | | --- | --- | | Mental Health Support 🞏  Telephone Advice & Support 🞏  PIP (New claims only) 🞏  Food Bank Vouchers 🞏 | Addiction Support 🞏  Housing Applications 🞏  White Goods Applications 🞏  Welfare Assistance 🞏  Other 🞏 |   If you have selected Other above, can you please explain what support is needed?  Is there any further information you would like to provide? |

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| 3. Details of the family members in the household | | | |
| Name | DOB | Gender | Support Needs Yes/ No (please state) |
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| 4. Risk & Accessibility |
| Are you aware of any access or risk issues that need to be taken into consideration when visiting or working with this client. Risk issues may relate to this family and/ or other people who visit the home. (Drug and Alcohol, Mental Health, Domestic Violence, Gang Related Violence, Pets etc) |
| Have you attached your own risk assessment? Yes 🞏 No 🞏 Pending 🞏 Not known 🞏 |

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| 5. Other Service involved (Consent to contact other agencies Yes 🞏 No 🞏) | | | |
| Name of worker | Organisation | Telephone | Email Address |
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| 6. Referrers Details | |
| Contact Name: | |
| Telephone No: | Email: |
| Organisation Name: | |
| Relationship to client: | |

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| 7. Client consent |
| Has the client consented to this referral? Yes 🞏 No 🞏 |
| Client Signature………………................ Print Name……………………………. Date………………………. |

Please return the completed form to:

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| **Email:** [**referrals@standingtallfoundation.org.uk**](mailto:referrals@standingtallfoundation.org.uk)  **Please ensure all sections of the form are completed before returning** |