Referral to KeyRing for support

**When you have filled in this form please email it to** [**tracey.lloyd@keyring.org**](mailto:tracey.lloyd@keyring.org)

Person being referred:

Their address:

Their phone number:

Has a single purchase contact been authorised? Please note KeyRing will not be able to start supporting without this in place.

YES/NO

Which team are they allocated to i.e. MH/LD/etc?

|  |  |  |
| --- | --- | --- |
| How do you know the person who wants to join KeyRing? | |  |
| How long have you known this person? | |  |
| Reason for referral? (Please explain the reasons and expected outcomes) | |  |
| Which tier of support is needed?  Full Member - weekly visit  Associate Member- fortnightly visits | |  |
| Current housing and support arrangements? | |  |
| Is person looking to be rehoused? If yes, are they on local authority housing register? | |  |
| **Please provide any relevant documentation** | | |
| Care Management Assessment has been provided | | Yes  No |
| Mental Health Assessment has been provided | | Yes  No |
| Other Assessments, Support or Care Plans provided – please detail | | Yes  No |
| If yes, please give details. |  | |

The information in the referral and any assessment sent is an accurate reflection of the support needs of the person being referred.

Name:

Date:

Phone number: