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| **KeyRing Application / Referral Form – Help When You Need It**  **This is a KeyRing service for people with Learning Disabilities or Autism living in the community**.  KeyRing is part of Bristol City Council’s range of ‘Tier 2’ “Help When You Need It” services across the City. The service will provide targeted short-term goals-oriented interventions for adults with eligible needs in Central, East & South Bristol. This service is provided at no cost to the applicant.  Please contact the Bristol Co-ordinator Zoe on tel: 07970 466 598or **email:** **tier2referrals@keyring.org** to refer yourself or chat with us about the service and how we can help. | | | | |
| **CLIENT INFORMATION**  *(please complete ALL sections in full)* | | | | |
| Date of referral *(dd / mm / yyyy):* | | Do you have the client’s consent to refer? *(Delete as appropriate)*  Yes No | | |
| Title *(Mr, Mrs, Miss, Ms, Dr, etc):* | First Name: | | | Surname: |
| Gender | Date of Birth: | | | Ethnic Origin of Client:  (i.e.. White British, Asian Indian) |
| Email address: | Emergency Contact: | | | Contact No: |
| Address (inc. post code): | | | GP Name, Address and Telephone Number: | |
| Reason for Referral. Please tick all that apply:   Support needed to maintain accommodation/tenancy or secure accommodation.   Support needed to manage physical health and wellbeing.   Support needed to manage mental health and wellbeing.   Support needed to maximise income, reduce debts, or find paid work.   Support needed to prevent loneliness and isolation.   Support needed to stay safe.  Support Summery *(Please briefly outline what this person needs help to achieve):* | | | | |
| **Is this person interested in Drop-in sessions while waiting for at-home support?**  *Our drop-in service will provide support for individuals that require digital support; bidding on HomeChoice, Universal Credit support, form filling, help with correspondence and phone calls, we run these drop ins around Bristol where people can access 1:1 support in a public setting*  *(Delete as appropriate)*  **Yes / No** | | | | |

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| **HOW DID YOU HEAR ABOUT KEYRING?** | | |
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| **REFERRER INFORMATION**  *(please complete ALL sections in full)* | | |
| Title (Mr, Mrs, Miss, Ms, Dr, etc): | First Name: | Surname: |
| Profession: | Telephone No: | Mobile No: |
| Email address: | | |

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| **RISK ASSESSMENT**  **This MUST be completed in full before a referral can be accepted.**  *(please avoid simple yes/no answers where appropriate and continue on a separate sheet if necessary, indicating below if you have done so)* | |
| **Risk** | **Response** |
| Does this person have a diagnosed Learning Disability or Autism? Please specify |  |
| What communication needs does the person have, and what adjustments would we need to make for this individual?  i.e. Easy read documents? Sensory considerations? Any other? |  |
| Is this person ready and wanting to engage in support that offers practical, goals-oriented support to move towards independence? |  |
| Does this individual have any other health or physical issues that may impact the way they are supported? Do any reasonable adjustments need to be made? |  |
| Is the meeting venue or environment likely to be a risk to the staff member? If yes, please state the danger. |  |
| Is this person likely to be a risk to the staff member when visiting client’s home? Is there a reason that the client cannot be visited by one person? If yes, please explain the risk in full and specify alternative arrangements. |  |
| Is this person likely to be a risk to themselves? |  |
| Will there be anyone else there when I visit? If yes, whom? |  |
| Are there any drug and / or alcohol issues? |  |
| Is there any history of physical aggression? |  |
| Is there any history of verbal aggression? |  |
| Is there any forensic history with this client? Does this person have any prior convictions that we should know about? |  |
| Are there any risk factors towards other clients in group situations? |  |
| Are there any environmental issues we need to be aware of? Loud noises, crowds, lighting, etc. please state. |  |
| Are there any pets in the house? If so, what type? The client may be asked to put the pet in another room while the worker visits. |  |
| Are there any other risk factors you think we should know about? If yes, what are they? |  |

Person centred support that will be tailored to each individual. What does support look like?

* **One off pieces of work, and signposting to other services/agencies.**
* **Practical, goals-oriented support:** Length of support will be based on what goals need to be completed- up to a total of 12 months.
* **KeyRing membership:** After their initial support period, Members can get back in touch with us directly to request additional assessments and ask for support when problems arise for them.
* **All Members:** Have access to our online groups and weekly hubs that are held in various locations across Bristol. We use these hubs to build up our networks and promote community and inclusivity.
* **Out of Hours service:** Emergencies/welfare checks/medication prompts, available to all Members

The Co-ordinator will contact you within 3 working days to advise you on the status of the referral.

Any questions please contact us on **07970 466 598**

Referral form to be sent by secure email to:

[tier2referrals@keyring.org](mailto:tier2referrals@keyring.org )

If you do not have a secure email system, please let us know.

**Thank you for completing the form.**