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| **About the person** |
| Name: | Title: | Dob: | Gender: |
| Current Address:Postcode:Tel no:No fixed address [ ]   | Home address *(if different):*Postcode:Tel no: | GP:Surgery:Tel no: |
| How best to contact this person: |  |  |
| NHS no (if known):Police URN:Other ref no: | Ethnicity Choose an item. |
| **Concern** |
| Date of concern: Click here to enter a date. | Time (if known): |
| Where did the concern happen: |
| **What type of abuse is suspected? Please tick all appropriate** |
| Neglect/acts of omission |[ ]  Sexual Abuse |[ ]
| Self-neglect |[ ]  Modern Slavery |[ ]
| Domestic Abuse |[ ]  Discriminatory (including hate crime)  |[ ]
| Psychological/emotional  |[ ]  Physical |[ ]
| Financial/Material |[ ]  Organisational |[ ]
| Sexual Exploitation |[ ]   |  |
| **What are the concerns being raised; what are the risks for the person?** |
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| **Are there any known risks to other people or workers involved?** Choose an item. **If yes, please state below.** |
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| **If children are involved have Children’s Services been informed?** Choose an item. |
| **Is this an ongoing concern?** Choose an item. |
| **Does this person live alone?** Choose an item. |
| **What are the person’s primary needs?**  |
| **Choose an item.** |
| Other |
| **Preferred language/communication needs?** |
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| **Confidentiality and consent**  |
| Have you discussed raising this concern with the person? Choose an item. | Does the person consent for the Safeguarding concern to be reported to Adults’ Services? Choose an item. |
| If the answer to either/both of the above questions is **No**, please state the reasons for proceeding without consent? |
| What are the person’s views and what outcome do they want? |
| Does the person have mental capacity to be involved in the enquiry and protection plan? Choose an item.Does the person have a diagnosis or present in such a way that indicates that a mental capacity assessment is required? **(*please state*)** |
| Has a mental capacity assessment been arranged or taken place? ***(please state)***If a person is unable to give their own view is there someone they would like to represent their views? If so, provide name, relationship and contact details: |
| **Details of the person or organisation thought to be the cause of risk (if applicable)** |
| Name: | DOB: |
| Address: | Occupation: |
|  | Relationship to adult?  |
| Is the person or organisation who is thought to be cause of risk aware of this concern being raised? Choose an item. |
| **What action has already been taken to minimise risk for the person?**(Include any emergency medical treatment provided, evidence preserved and actions taken to prevent further abuse.)  |
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| **Please tick if any other agencies have been alerted** |
| Care Quality Commission (CQC) |[ ]  Sussex Partnership NHS Foundation Trust  |[ ]
| Police |[ ]  Sussex Community Trust |[ ]
| Hospital (please name which) |[ ]  Clinical Commissioning Group |[ ]
| General Practitioner (GP) |[ ]  Contracts and Commissioning |[ ]
| Fire Service |[ ]  Other, if other please state: |
| **Details of person completing the referral** |
| **Name:** | **Date concern form sent to adults’ services:**Click here to enter a date.**Please return form to** **socialcare@westsussex.gov.uk** |
| **Landline:** |  |
| **Mobile:** |  |
| **Email:** |  |
| **Organisation:** |  |