



**REFERRAL TO RESIDENTIAL RECOVERY SERVICES**

**CYPRESS** 35 Totnes Road, Paignton TQ4 5LA  
01803 551066

**GRANVUE** Lincombe Drive, Wellswood, Torquay  
TQ1 2HH 01803 213970

**ST MAUR** 8 Knowles Hill Road, Newton Abbot  
TQ12 2PH 01626 335560

**(A) 1. CLIENT DETAILS**

Mr Mrs Miss Ms

SURNAME .....

FORENAMES .....

ADDRESS .....

.....

TOWN ..... POSTCODE .....

TELEPHONE NUMBER (code) ..... (no.) .....

MOBILE TELEPHONE NUMBER .....

MHA STATUS .....

**2. DATE OF BIRTH**

**GENDER**

**3. GP DETAILS**

NAME .....

SURGERY .....

TELEPHONE NUMBER (code) ..... (no.) .....

**4. LIVING SITUATION**

	Yes	No	
ALONE	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
WITH PARENTS	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
WITH RELATIVE	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
WITH CHILDREN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
WITH CARER	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
WITH FRIEND	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>

**5. OTHER AGENCIES / PROFESSIONALS INVOLVED**

NAME	AGENCY	ACTIVITY	CONTACT NUMBER
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

**6. REFERRED BY**

NAME .....

DESIGNATION .....

BASED AT .....

SIGNATURE ..... DATE .....

CONSULTANT DETAILS .....

**7. MOST RECENT: HOSPITAL / ADMISSION**

HOSPITAL .....

WARD .....

DATE .....

DURATION .....

DETAILS .....

.....



**C. ASSESSMENT AND RISK CHECK LIST**

1. Is this person vulnerable, e.g. risk of abuse / self harm / accidents etc?  Yes  No

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2. Is there evidence of deterioration in mental health?  Yes  No

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3. Is there evidence of deterioration in physical health?  Yes  No

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4. Have there been any recent changes in circumstances?  Yes  No

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5. Are there any indicators or potential risks of violence / aggression to staff / others / self?  Yes  No

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6. Are there unresolved problems with mobility, personal care, moving and handling tasks?  Yes  No

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7. Does substance abuse seem to be an issue?  Yes  No

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8. Are there any other issues that concern you?  Yes  No

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**HAS THIS REFERRAL BEEN DISCUSSED WITH THE PERSON BEING REFERRED?**  Yes  No

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(CCT USE ONLY) REFERRAL RECEIVED ON

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APPOINTMENT MADE WITH CARE CO-ORDINATOR

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**FOR CCT USE ONLY:**

**REFERRAL AND REVIEW PANEL – Date .....**

Agreed assessment response:

**REFERRAL AND REVIEW PANEL – Date .....**

Assessment summary:

Agreed response: