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| **Multi-agency Adult Protection/Adult Concern Referral Form (APR)** |

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| Adult Protection Referral |  | Adult Concern Referral |  |

**Complete the form as fully as possible, but don’t allow a lack of information to delay a referral**

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| **ADULT DETAILS** | | | | | |
| Name: |  | | DOB: |  | |
| Home Address: |  | | Current Whereabouts |  | |
| Postcode: |  | | Tel No: |  | |
| Tel No: |  | | CHI/Social Work Reference No (if known) |  | |
| Gender: | Choose an item. | Ethnicity: | Choose an item. | Religion: | Choose an item. |
| Communication Support  (please provide details including communication aids needed by the adult) | | |  | | |
| Advocacy Support  (please provide details of any advocacy support in place, referral made or any other support requested by adult) | | |  | | |
| GP Name, Address, Tel No (if known) | | |  | | |
| Parenting/Carer Responsibilities: (please provide details of any children or adults that the adult at risk may be responsible for) | | |  | | |

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| **REFERRER DETAILS** | | | | |
| Name: |  | | Designation: |  |
| Agency: |  | | Direct Dial Tel No: |  |
| E-Mail: |  | | | |
| Relationship to adult being referred: | |  | | |
| Date of Referral: | |  | | |

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| **DETAILS OF CONCERN** | | |
| The Adult is affected by disability, mental disorder, illness or physical or mental infirmity (if yes, please specify)   **YES or NO** | |  |
| The Adult is unable to safeguard their own wellbeing, property, rights or other interests - **YES or NO** | |  |
| The Adult is at risk of harm (if yes, please state reason and type of harm) - **YES or NO** | |  |
| If you have answered yes to all of the above questions, please tick Adult Protection Referral. If you have been unable to answer yes to all of the above questions, please tick Adult Concern Referral. | | |
| Give details of harm (suspected/witnessed/disclosed/reported) Include details of any previous AP Referrals/Concerns if known. (please use separate sheet if required) | | |
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| Date of Incident: |  | |
| Have you (or any other person) told the adult that this information will be shared with Social Work or other relevant agencies? | YES / NO(delete as appropriate) If **NO** please state reasons | |
| Is it suspected that a crime has been committed and have police been informed?  (Include date, time, known action taken, incident number etc.) | | |
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| **DETAILS OF PERSON REPORTED TO BE CAUSING HARM (If known) Please PRINT details** | | | |
| Name: |  | Relationship to Adult: |  |
| Address: |  | Tel No: |  |

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| **REFERRAL FORM TO BE SENT WITHIN 24 HOURS OF IDENTIFYING A CONCERN TO** | |
| East Ayrshire Health & Social Care Partnership | [H&SCPCustomerFirst@east-ayrshire.gov.uk](mailto:H&SCPCustomerFirst@east-ayrshire.gov.uk) |
| North Ayrshire Health & Social Care Partnership | [adultprotection@north-ayrshire.gcsx.gov.uk](mailto:adultprotection@north-ayrshire.gcsx.gov.uk) |
| South Ayrshire Health & Social Care Partnership | [ASP@south-ayrshire.gov.uk](mailto:ASP@south-ayrshire.gov.uk) |
| For assistance out of hours contact: | 0800 328 7758 |

**Remember – An ASP Referral is not an emergency service – if necessary, phone 999 to access immediate assistance**