

STEPPING STONE PROJECT

Referral AND Risk Assessment Form

Supported Accommodation Projects

Ashburn House
School St
Angel Meadow
Heywood
OL10 3EG

TEL: 01706 366930
FAX: 01706 361729

Parkside
Bowness Rd
Langley
Middleton
M24 4WT

0161 643 1722
0161 653 0439

Redfearn House
Ings Avenue
Rochdale
OL12 7LH

01706 526296
01706 345302

Westgate
56 Westgate
Burnley
BB11 1RY

TEL: 01282 422209
FAX 01282 422235

Spa Mill
14 Whittle Court
Burnley
BB12 0LY

01282 455780
01282 455799

Spenser St
19 Spenser St
Padiham
BB12 8SL

01282 455780
01282 455799

Grange Avenue Project
48 Grange Avenue
Latchford
Warrington

TEL: 01925 654224
FAX: 01925 654224

Client Details

Name	
Current Address	
Contact number	
Date of birth	
NI No	
Gender	
Ethnic origin	
Marital status	
Dependents	
Next of kin	
Relationship	
Contact Address	

Referring Agency Details

Date	
Referring Agency	
Contact Person	
Email address	
Contact Number	
Please state which service you are applying for?	

Is the client aware of this referral being made?.....

Is the client in agreement with this referral being made?.....

1) Has the client ever used any of the services offered by Stepping-Stone previously?

- Yes
- No

2) If YES which services have they used and who was their Resettlement Worker or Floating Support Worker?

Project	Dates	Member of Staff
Parkside		
Redfearn House		
Ashburn House		
Westgate		
Spa Mill		
Spenser St		
Floating support		

3) What do you think the client needs support with? Please tick

INITIAL SUPPORT ASSESSMENT

Outcome	Area of support	Examples	Do you feel you need support with this?
ACHIEVE ECONOMIC WELL BEING	MANAGING MONEY	Claiming Benefits / IS, JSA, etc	
		Claiming and sustaining Housing Benefit	
		Maximising Income	
		Claiming Grants / Allowances	
		Budgeting	
		Managing debts	

		Setting Up and maintaining Payment Plans	
		Access specialist services	
		Gambling Issues	
ENJOY AND ACHIEVE	USE OF TIME	Educational opportunities	
		Training Opportunities	
		Client Involvement	
		Hobbies & Interests	
		Leisure opportunities	
		Parenting Skills	
		Cultural / Faith Needs	
	FAMILY AND RELATIONSHIPS	Improving relationship Partner	
		Improving Family relationships	
		Establishing Social Networks	
BE HEALTHY	PHYSICAL HEALTH	Accessing primary health care / GP	
		Reduce Crisis situations	
		Keeping healthy	
		Anger management	
		Sexual health	
	EMOTIONAL OR MENTAL HEALTH	Managing depression / anxiety	
		Managing mental health	
		Link in to mental health related services	
		Emotional stability	
	DRUGS, ALCOHOL, OTHER ADDICTIONS	Link in with specialist alcohol support services	

		Link in with specialist drug support services	
		Manage substance misuse	
	KEEPING HOUSE AND SELF CARE	Cooking	
		Cleaning	
		Shopping	
		Personal Safety	
		Personal Hygiene	
		Familiarise with local facilities and services	
STAY SAFE	ABILITY TO MANAGE TENANCY	Managing visitors	
		Paying rent & charges	
		Understanding Tenancy Rights & Responsibilities / Tenants & Landlords	
		Understanding Tenancy Agreement	
		Setting Up New Tenancy	
		Utilities	
		Accessing Furniture	
		Finding a more permanent home	
		Ongoing housing related support	
	OFFENDING	Reducing Offending Behaviour	
		Compliance with probation requirements	
		Reduce / stop anti social behaviour	
	PHYSICAL HEALTH	Reduce Self harm	
		Reduce harm to others	

Accommodation History

Please provide details by ticking the appropriate box if any of the following problems were encountered in current or previous accommodation?

Address	Current tenancy arrears	Former tenant arrears	Recharges	Hsg Benefit Overpayment	Anti Social Behaviour	Abandonment	Other Issues

If you have ticked yes to any of the above please provide further details

Violence	
Physical Health Problems	
Learning Difficulties	
Learning Disabilities	

Does the client have any convictions relating to? Please tick

	Yes	No	N/K	Outcome/Sentence
Arson				
Assault				
Burglary				
Criminal Damage				
Drugs				
Sexual Offences				
Theft				
Violence				
Others Please State				

If you have ticked yes to any of the above please could you provide further details of the offence committed?

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Joint working

Will you still be providing some support to the client if they are accepted onto Stepping Stone Project Service?

- Yes
- No

If yes, how frequently would you like to liaise with our support staff and which means of communication would you prefer?

- Weekly
- Monthly
- Quarterly
- Six monthly
- As required

- Letter
- Email
- Telephone
- Text
- Meeting

Would it be beneficial to agree a joint support plan, between our two organisations and the client (if they are in agreement), to prevent duplication of work and reduce confusion?

Please select the best means of confirming the date, time and place of the needs and risk assessment meeting:

- letter
- telephone
- text
- email

Date and Signature of person making the referral

Signature:

Print Name:

Capacity:

Date:

STEPPING-STONE PROJECT

CLIENT RISK ASSESSMENT FORM

NAME		DATE OF BIRTH	
ADDRESS			

Presenting Problems (including views of client, support staff and referrer):

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Danger / Risk to Others	Current	Previous History	Brief Description of the risk, trigger factors and signs	Are Risk Low, Medium or High
Aggression / Violence to Others				
Violence towards staff				
Arson / Fire Setting				
Sexual abuse				
Other				
Self Harm	Current	Previous History	Brief Description of the risk, trigger factors and signs	Are Risk Low, Medium or High
Any Suicidal Attempts, thoughts or plans				
Self-harm / Injury (e.g. cutting, poisoning, burning)				
Other				

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Self Neglect	Current	Previous History	Brief Description of the risk, trigger factors and signs	Are Risk Low, Medium or High
Poor nutrition				
Poor personal hygiene				
Unable to cook / have good diet				
Unable to wash / dress self				
Poor budgeting				
Other				

Vulnerability	Current	Previous History	Brief Description of the risk, trigger factors and signs	Are Risk Low, Medium or High
Non-compliance with medication				
Disengagement from mental health services				
Recent bereavement or loss				
Sexual abuse / other abuse				
Victimisation				
Financial abuse				
Domestic violence				

Neighbour harassment				
Recent Discharge				
Recent Pregnancy				
Other				

Substance Abuse	Current	Previous History	Brief Description of the risk, trigger factors and signs	Are Risk Low, Medium or High
Alcohol misuse				
Drug misuse				
Prescribed drugs				
Other				

Assessment completed by:

TITLE		NAME	
ADDRESS			
TELEPHONE			
FAX			
EMAIL			
RELATIONSHIP TO YOU			

WHAT PRACTICAL/POSITIVE MEASURES CAN BE PUT IN PLACE BE TO MINIMISE THE RISK(S)? Visits in pairs/gender specific worker/office appointment only/only visit at a set time/leave if under the influence of a substance, behavioural contract etc.

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Signature:		Date:	
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