**Assessment Form**

|  |  |
| --- | --- |
| Forename: | Surname: |
| Prefer to be known as: | Contact Tel: |
| Gender:  Date of birth:  Marital status:  Height:  Weight: | Address:  Post Code: |
| Previous Occupation: | NI no. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Next of Kin: Relationship:  Next of Kin Address:  Postcode: Contact Number: | | | | |
| Children:  Yes / No | Name & Contact No. 1.  2. | | | |
| Residential status (tick the answer)  Living with friends Living with family Hostel  Housing Association Hospital  Council Tenant Secure Accommodation  Private rented Homeless | | | Other (Please State)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Referral Details | | | | |
| Name of referrer: | | Contact Numbers:  Email: | | |
| Team/Agency name and address  (if applicable) | | | | |
| Does the client know they are being referred to the service? | | | | Yes / No |

|  |  |
| --- | --- |
| Have any other referrals been made for floating support or is the client awaiting a decision following a recent assessment from another agency?  Yes / No  If yes please specify below: | |
|  | |
| Existing Support | |
| If you have ticked any of the boxes below please provide details e.g. name, agency contact details | |
| Social Worker Carer/Family  Probation Officer CPN  Assertive Outreach Team Psychiatrist  Drugs/Alcohol Agency OT  Voluntary Organisation G.P. | Other (Please State)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If you have underlined any of the above please provide details e.g. name, agency, contact details | |
| Mental Health | |
| *Give details of the nature of the client’s Diagnosis. Please include timescales, triggers and coping mechanisms.* | |