

Referral Form

Buckinghamshire Floating Support Service

Applicants name/s :
Current address :
Date of birth/s:
Telephone / Contact details:
Date of referral:
Communication barriers / preferred language:
If applying for a young families service, please indicate the expected due date;

Network of Support

Support Network Members	Please tick as many as applicable ✓	Names	Contact Details
Friends			
Family Members			
Carer(s)			
General practitioner			
Psychiatrist			
Community mental health nurse (CPN)			
Social worker			
Support worker (s)			
Midwife			
Health visitor			
Other (<i>please specify</i>)			

Support Needs

Please indicate areas where you believe the service user requires support	Please tick as many as are applicable ✓	Note any relevant details
Benefits/HB/Form completing		
Budgeting		
Difficulty reading or/and writing		
Eviction		
First tenancy/Sustaining tenancy		
Harassment		
Leaving care		
Maintaining property		
Neighbour disputes/ASB		
No support/social networks		
Parenting skills		
Rent arrears/debt		
Unsettled housing history		
Other (please specify)		

Any other additional information relevant to support needs or referral in general

Continue on a separate sheet if necessary

Monitoring our Services – Scheme Name

We are committed to providing a service, which is fair and available to everyone. To help us monitor this, please answer the following questions. Your response will be separated from this form and kept confidential.

Gender Male Female

Do you consider yourself to have a disability Yes No

Ethnic origin of applicant:

- A – White British Irish Other
- B – Mixed White and Black Caribbean White and Black African White and Asian
Other
- C – Asian or Asian British Indian Pakistani Bangladeshi Other
- D – Black or Black British Caribbean African Other
- E – Chinese or other
Ethnic group Chinese Other
- F – Refused

-