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| VA1 - Adult Protection Referral Form – Confidential *(April 2011)*  ***Please complete as fully as possible, especially ensuring that risks are identified.***  For office use only  Date received by DLM -  Date of Stage 3 review - | | |
|  | | |
| **1 About the Vulnerable Adult (Subject of referral)** | | |
| Date alert/ concern raised | Date(s) of Incident(s) if known: | |
| Name:  Client/Patient ID Number: |
| Date of birth: | Gender: Male Female | |
| Vulnerable Adult/Client’s Current Address: | Other Vulnerable Adults / Children living at the property: | |
| Tel Number: | **Main Client Group (tick ONE only):**  Elderly Mentally Infirm  Older Person  Visual Impairment  Hearing impairment  Learning Disability  Mental Health  Physical Disability  Substance Misuse  Other | |
| Marital Status: |
| Ethnicity: |
| First Language: |
| Need Interpreter: Yes No |
| GP’s Name:  Telephone Number:  ­Surgery Address: |
| **Case Status (Social Services use only :**  Open/active  Open, review only  Closed  Not previously known  Other County | |
| Next of kin: | | Relationship: |
| Address:  Telephone number: | | |
| Is the vulnerable adult aware of the referral? Yes No | | |
| Has the vulnerable adult consented to the referral? Yes No | | |
| Is there any evidence to suggest that the vulnerable adult lacks mental capacity to consent to this referral? Yes No | | |

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| **2 About the alleged abuse** | | | |
| Type of alleged abuse (tick all relevant boxes)  Physical  Sexual  Emotional/Psychological Financial/Material  Neglect  Of which is  Racial  Domestic | | | |
| Personal circumstances – Is the alleged victim subject to any legislative powers, e.g. Mental Health Act, Power of Attorney, DoLS? | | | |
| Where did the alleged abuse occur? | | | |
| Own Home  Perpetrator’s home  Relative’s Home  Supported Tenancy  Sheltered  Accommodation. | Care Home – Residential  Care Home – Nursing  Care Home – Respite  Hospital – NHS  Hospital – Independent  NHS Group Home Hospice | | Day care  Educational est.  Public place  Other - Please State: |
| Specific location of abuse (e.g. Ward/ Dept, Hospital, Care Home) | | | |
| Is the abuse: Historical Current | | | |
| Description of alleged abuse/injuries:  *(continue on separate sheet of paper if necessary)* | | | |
| **2a.** Please use the section below to identify the position of any marks, bruising, wounds etc described above | | | |
|  | |  | |
| What steps have been taken to safeguard the vulnerable adult and by whom: | | | |

**3 About the person(s) allegedly responsible for the abuse**

**Person 1:**

|  |  |  |
| --- | --- | --- |
| Unknown at present: | | |
| Name: | Address: | |
| Tel No: | Date of Birth: | |
| Age: | Relationship to Alleged Victim: | |
| Employing Agencies. List all known: | | |
| Is alleged perpetrator a vulnerable adult? Yes  No  Don’t know | | |
| Is alleged perpetrator a child? Yes  No  Don’t know | | |
| Is alleged perpetrator aware of the referral? Yes  No  Don’t know | | |
| Is the Alleged perpetrator known to social services? Yes  No  Don’t know | | |
| If yes, Client/Patient Database Number: | | Team responsible: |
|  | | |

**Person 2:**

|  |  |  |
| --- | --- | --- |
| Unknown at present: | | |
| Name: | Address: | |
| Tel No: | Date of Birth: | |
| Age: | Relationship to Alleged Victim: | |
| Employing Agencies. List all known: | | |
| Is Alleged perpetrator a vulnerable adult? Yes  No  Don’t know | | |
| Is Alleged perpetrator a Child? Yes  No  Don’t know | | |
| Is Alleged perpetrator aware of the referral? Yes  No  Don’t know | | |
| Is the Alleged perpetrator known to social services? Yes  No  Don’t know | | |
| If yes, Client/Patient Database Number: | | Team responsible: |

***If more than two alleged perpetrators have been identified please photocopy this page or add details in Section 8 – Additional information.***

**4 About the people who witnessed the incident(s)**

**Witness 1**:

|  |  |
| --- | --- |
| Name: | Address: |
| Tel No: | Relationship to victim (if any): |
| Is witness a child? Yes  No  Don’t know | |
| Is witness a vulnerable adult? Yes  No  Don’t know | |
| Is witness aware of referral? Yes  No  Don’t know | |

**Witness 2**:

|  |  |
| --- | --- |
| Name: | Address: |
| Tel No: | Relationship to victim (if any): |
| Is witness a child? Yes  No  Don’t know | |
| Is witness a vulnerable adult? Yes  No  Don’t know | |
| Is witness aware of referral? Yes  No  Don’t know | |

**5 About the person who first reported the concern** *(This is the first person to raise the alert – it may be the Vulnerable Adult, a witness or someone with concerns)*

|  |  |
| --- | --- |
| Is the person reporting the incident the vulnerable adult? Yes  No  Is the person reporting the incident a witness to the incident? Yes  No | |
| Name: | Address: |
| Tel No: | Occupation/Relationship: |
| Date/Time report: |  |
| Does the reporter wish to remain anonymous? Yes  No  If yes, please state why: | |

**6 About the person who is referring the incident(s) to Social Services or Health Board**

|  |  |
| --- | --- |
| Is the person referring the incident a witness to the incident? Yes  No | |
| Name: | Address: |
| Tel No: | Occupation/Relationship: |
| Date/Time reported: | |
| Does the referrer wish to remain anonymous? Yes  No  If yes, please state why: | |

**7 Details of person completing this form**

|  |  |
| --- | --- |
| Name: | Designation: |
| Agency: | Time/Date completed: |
| Signature: | Telephone number: |

**8 Additional Information**

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| --- | --- |
| **Where applicable, details of countersigning line manager:** | |
| Name: | Designation: |
| Signature: | Time/Date countersigned: |