**Camden Safeguarding Adults Partnership Board**

**Multi-agency Safeguarding Adults Referral Form**

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|  **THIS FORM IS NOT TO BE USED BY MEMBERS OF THE PUBLIC.**  **MEMBERS OF THE PUBLIC SHOULD PHONE 020 7974 4000**   **AND THEN PRESS OPTION 1.**   **Use this form to refer any incident or suspicion of harm.** **If outside normal office hours or at the weekend or on a Bank Holiday, please contact** **OUT OF HOURS EMERGENCY DUTY TEAM on 020 7974 4444.** **Where a criminal act may have been committed, the police must be  notified immediately on 101 (non-urgent) or 999 (urgent).**   |





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|  **Section 1: DETAILS OF ADULT AT RISK**  |
| **NAME**  |  | **DOB**  |  |
| **AGE** *(if DOB is unknown)*  |  | **GENDER**  |  |
| **ADDRESS**  |  | **TEL NO**  |  |
| **DETAILS OF NEXT OF KIN/OTHER CONTACT**  |  |
| **HAS THE ADULT AT RISK** **PROVIDED CONSENT FOR THIS** **CONCERN TO BE RAISED?**  | [ ] **Yes** [ ]  **No**  | *If no, please state reason(s).* |
| **DO YOU THINK THE ADULT AT** **RISK HAS MENTAL CAPACITY** **IN RELATION TO MAKING** **DECISIONS ABOUT THEIR** **SAFETY?** | [ ]  **Yes** [ ]  **No** | *Please provide further details if available.* |
| *Is there a suitable person who could represent them? (e.g. family member, friend, advocate)* [ ]  **Yes** [ ]  **No***If yes, please provide details*. | *Has a mental capacity assessment been undertaken?* [ ]  **Yes** [ ]  **No***Please provide details*. |
| **DO YOU THINK THE ADULT AT** **RISK WOULD HAVE** **SUBSTANTIAL DIFFICULTY IN** **PARTICIPATING IN THE** **SAFEGUARDING ENQUIRY** **PROCESS?**  | [ ]  **Yes** [ ]  **No** | *If yes, please provide details*. |
| **HAS THE ADULT AT RISK’S** **FAMILY BEEN INFORMED OF** **THE CONCERNS (WHERE THE** **ADULT HAS CONSENTED TO** **THIS)?**  | [ ]  **Yes** [ ]  **No** | *Please provide details*. |

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| **SERVICE USER GROUP** |  |  | Service User Sub-group  |  |
| **ETHNICITY** |  |  |
| **FIRST LANGUAGE** |  | *Detail communication needs.* |
| **NHS NUMBER*****(If known)*** |  |  |
| **Section 2: CONCERN**   |  |
| **BRIEF FACTUAL OUTLINE OF CONCERN**  |  |    |
| **DATE OF CONCERN**  |  |  |
| **LOCATION OF INCIDENT**  |  |  |
| **TYPE(S) OF ABUSE – PLEASE SPECIFY**  |  |  |
| **ARE THERE ANY CHILDREN INVOLVED?**  |  | [ ]  **Yes** [ ]  **No*****If yes, please refer to Children’s MASH by email*****LBCMASHAdmin@camden.gov.uk.cjsm.net or telephone 020 7974 3317** |
| **TYPE OF INCIDENT**  |  |  |
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| *If self-neglect, please skip to*  |

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|  | *Section 4* |
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|  **Section 3: PERSON/ORGANISATION ALLEGED TO HAVE CAUSED HARM (PACH)**  |
| **NAME**  |  | **DOB**  |  | **AGE** *(if DOB is* *unknown)* |  | **GENDER**  |  |
| **ADDRESS**  |      |
| **TELEPHONE NO**  |  |
| ***If professional/volunteer,******please specify***  |  | *If other, please specify*  |  |
| **Was alleged PACH living with the adult at time of abuse?**  | [ ]  **Yes** [ ]  **No**  | *Still living with adult?*  | [ ]  **Yes** [ ]  **No** |
| **If the allegation is of organisational abuse, please name the provider:**  |   |
| **PLEASE GIVE DETAILS OF** **IMMEDIATE ACTION** **TAKEN TO TRY AND REDUCE RISKS:**  |    |
| **SECTION 4: ORGANISATIONS** **INVOLVED**  |
| *NAME*  | *JOB TITLE*  | *ORGANISATION* *(SOCIAL SERVICES,* *CQC, POLICE, GP)*  | *CONTACT DETAILS PHONE NUMBER* *EMAIL ADDRESS* |
|    |   |   |        |
| HAVE THE POLICE BEEN NOTIFIED?   | [ ]  **Yes** [ ]  **No** | CRIME REFERENCE NO  |   |
| PROVIDE DETAILS IF MEDICAL ATTENTION GIVEN:  |   | NAME OF HOSPITAL/DOCTOR  |    |

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| **SECTION 5: REFERRER DETAILS**  |  |  |  |
| **CONCERN REPORTED BY:**  | Service user  | [ ]  | Friend   | [ ]  |
| Relative   | [ ]  | Paid carer  | [ ]  |
| Social Worker   | [ ]  | Stranger  | [ ]  |
| GP   | [ ]  | Nurse  | [ ]  |
| Hospital Doctor / Staff  | [ ]  | Therapist  | [ ]  |
| Provider or Voluntary Organisation (please specify)  |   |  |  |
| Other (please specify)  |     |  |  |
| **SECTION 6: DESIRED OUTCOMES**   |  |  |  |
| **DESIRED OUTCOME(S) OF ADULT AT RISK**  |     |  |  |  |
| **DESIRED OUTCOME(S) OF REFERRER**  |     |  |  |  |

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| **DETAILS OF THE PERSON COMPLETING THIS FORM**  |  |  |
| *NAME*  | *JOB TITLE*  | *TELEPHONE NUMBER*  | *EMAIL*  |
|  |  |  |  |

***Once the Adult MASH team have received your referral form by email, you will receive confirmation that the Concern is being screened.***

***If further information is required, you may be contacted by***

***a MASH social worker.***

**Please note that this form is to be sent securely via Egress/CJSM to**

**asc.mash.safeguarding@camden.gov.uk.cjsm.net**

 **More details on Camden's Safeguarding Policy can be found here:**[www.camden.gov.uk](https://www.camden.gov.uk/ccm/content/social-care-and-health/about-social-care/protecting-a-vulnerable-adult.en?page=1)