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| **Dumfries & Galloway Multi-Agency Adult Protection Referral Form - AP1 Form**FOR USE BY ALL AGENCIES & CARE PROVIDERS (EXCEPT POLICE) |

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| Adult Concern for adults where you know or believe they are at risk of harm  |  | Adult Protection Referral if agreed by a Manager in your service (care agencies only) |  |

**Complete the form as fully as possible, but don’t allow a lack of information to delay a referral**

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| **ADULT DETAILS** |
| Name: |  | DOB: |  |
| Home Address: |  | Current Whereabouts |  |
| Postcode: |  | Tel No: |  |
| Tel No: |  | CHI/Social Work Reference No (if known) |  |
| Gender: |  | Ethnicity: |  | Religion: |  |
| Communication Support(please provide details including communication aids needed by the adult) |  |
| Advocacy Support(please provide details of any advocacy support in place, referral made, or any other support requested by adult) |  |
| GP Name, Address, Tel No (if known) |  |
| Parenting/Carer Responsibilities: (please provide details of any children or adults that the adult at risk may be responsible for)(Please make a separate referral for children who may be at risk of harm) |  |

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| **REFERRER DETAILS**  |
| Name: |  | Designation: |  |
| Agency: |  | Direct Dial Tel No: |  |
| E-Mail: |  |
| Relationship to adult being referred: |  |
| Date of Referral: |  |
| Has Referral already been reported to Social Work by telephone?  |  |

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| **DETAILS OF CONCERN**  |
| Is the Adult affected by disability, mental disorder, illness or physical or mental infirmity? **YES or NO** (if **yes,** **please specify)**    |  |
| Is the Adult unable to safeguard their own wellbeing, property, rights or other interests? **YES or NO (if yes, please specify)**  |  |
| Is the Adult is at risk of harm (if yes, please state reason and type of harm) - **YES or NO (if yes, please specify** |  |
| Are there other factors which mean that this person is vulnerable or at risk? Yes or No, please outline key factors e.g. is there a pattern to the concerns; is this an accumulation of factors |  |
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| Give details of harm/**concern** (suspected/witnessed/disclosed/reported) Include details of any previous AP Referrals/Concerns if known**. Please answer the questions below in as much detail as possible.**  |
| What worries do you have that made you contact us today? |
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| How safe is the adult? |
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| How safe do you think they will be tonight and tomorrow if nothing changes? |
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| How long have you been worried about this child/person? |
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| What are you most worried about?  |
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| What have you done to help?  |
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| What do you think, given what you know about this person, could be done to help? |
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| Date of Incident (If different from referral date): |  |
| Have you (or any other person) told the adult that this information will be shared with Social Work or other relevant agencies? | YES / NO(delete as appropriate) If yes please state reasons |
| Is it suspected that a crime has been committed and have police been informed? Please add below(Include date, time, known action taken, incident number etc.) |
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| **DETAILS OF PERSON REPORTED TO BE CAUSING HARM (If known) Please PRINT details**  |
| Name: |  | Relationship to Adult: |  |

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| **DETAILS OF MAIN CARER / RELATIVE / POWER OF ATTORNEY / GUARDIAN (please PRINT details)**  |
| Name: |  | Relationship to Adult: |  |
| Address: |   | Tel No: |  |

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| Social Work Access Team email contact: | AccessTeam@dumgal.gov.uk |
| Social Work Access Team Telephone contact: | **030 33 33 3001** |
| Social Work Out of Hours Team email contact: | socialworkoutofhours@dumgal.gov.uk |
| Social Work Out of Hours Telephone contact:  | **030 33 33 3001** |

**Remember – An ASP Referral is not an emergency service – if necessary,**

**phone 999 to access immediate assistance**

You will receive an acknowledgement of your referral within 24 hours and feedback on the progress of your referral within 5 working days.