

## THRESHOLD FLOATING SUPPORT TENANCY PROGRAMME REFERRAL FORM

### **PERSONAL DETAILS**

Name: \_\_\_\_\_

D.O.B: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Current Address: \_\_\_\_\_

\_\_\_\_\_

Postcode: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

### **HOUSING INFORMATION**

Type of Accommodation (Please State): \_\_\_\_\_

#### **Details of others living at this address:**

NAME	RELATIONSHIP TO APPLICANT

#### **Details of all professionals involved with the individual:**

DESIGNATION	NAME	ADDRESS	TELEPHONE No
G.P			
Social Worker			
CPN			
Psychiatrist			
Other			

### **TYPE OF SUPPORT REQUIRED**

Please identify the support you require by ticking and giving a brief description . This support will be give weekly and for a max of 6 months.

# Threshold

- ❖ Support with Mental health   
\_\_\_\_\_
- ❖ Managing daily living tasks within the home   
\_\_\_\_\_
- ❖ Money management   
\_\_\_\_\_
- ❖ Developing External activities   
\_\_\_\_\_
- ❖ Personal safety   
\_\_\_\_\_
- ❖ Appointment support   
\_\_\_\_\_
- ❖ Medication confidence   
\_\_\_\_\_
- ❖ Other:   
\_\_\_\_\_  
\_\_\_\_\_

## MEDICAL DETAILS

### Current Physical Health


### Mental health Diagnosis:


## MEDICAL/PSYCHIATRIC DATA

### Last hospital treatment:

Hospital: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Reason for admission: \_\_\_\_\_

Treatment: \_\_\_\_\_

(Attach further sheet if necessary)

**Current Medication:**

Drug	Dose	Self admin (Y) (N)

**SOCIAL HISTORY/BACKGROUND (Attach further information if available)**

**DETAILS OF ALL DAY ACTIVITY**

Please indicate all day care/activities: \_\_\_\_\_

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**RISK ASSESSMENT**

Please provide details of suicide attempts, self-harm, violence/aggression, charges/convictions for violence, arson, sexual offences, etc.

Is the client a current suicide risk? \_\_\_\_\_

Is the client agreeable to this referral? YES / NO

Referral Agent: \_\_\_\_\_ Date: \_\_\_\_\_

Professional: \_\_\_\_\_ Designation: \_\_\_\_\_  
Print

Service User: \_\_\_\_\_ Date: \_\_\_\_\_

Please attach a copy of current: Risk Assessment (from CMHT)  
Psychiatric History (from CMHT)  
Monitoring Form

**Application pack must be returned with full accompanying documentation before the application can be processed**

Please forward referral to: **Threshold Floating Support Tenancy programme**

**Willow House**

**3-7 Brookhill Avenue. Belfast. BT14 6BS**

## Threshold Floating Support Tenancy programme Consent Form

### **About this form:**

In order for us to proceed with your referral for Threshold Floating Support Service we may need to access additional information. This includes information on your psychiatric history and any current relevant information. In order for this information to be released from your medical records could you please complete the form below and return to: *Floating Support, Willow House , 3-7 Brookhill Avenue, Belfast, BT14 6BS.*

### **Written Consent Section**

I..... (Insert name) hereby consent to the request and release of the following records to Threshold Floating Support at the above address :

#### Specific Information to be released:

.....Psychiatric history, G.P and any other relevant information.....

Signature .....

Print Name .....

Date .....

## THRESHOLD MONITORING FORM

**Threshold** 

## FAIR ACCESS

The Northern Ireland Act 1998, places duties on organisations, including Threshold, to have due regard to the need to promote fair access to our services:-

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women;
- between persons with a disability and those without; and
- between persons with dependents and those without.

These are generally referred to as the Section 75 categories.

Threshold has an Equality Policy which sets out how we will meet the statutory equality duties. In order to constantly monitor our policies we need additional information on those who are affected by them in relation to the Section 75 categories.

Please find attached a form, from which this information will be gathered and which Threshold will treat in the strictest confidence. **The information you provide will be managed so as to fully protect your confidentiality.**

## SECTION 75 MONITORING QUESTIONNAIRE

1. To which of these ethnic groups do you consider yourself to belong?

- White
- Chinese
- Irish Traveller
- Indian
- Pakistani
- Bangladeshi
- Black Caribbean
- Black African
- Mixed ethnic group
- Other ethnic group

2. Do you consider yourself to have a disability?

By disability we mean any physical, sensory, mental or learning impairment that has a substantial and long term (lasted or expected to last 23 months or more) adverse impact on your ability to carry out normal day to day activities, without mechanical or electronic assistance or the adaptation of your workplace.

- Yes
- No

3. Please indicate your community background

- I have a Protestant community background
- I have a Roman Catholic community background
- I have neither a Protestant nor a Roman Catholic community background

4. What is your marital status?

- Married/Civil Partnership
- Living with a partner
- Single (never married)
- Separated/divorced
- Widowed

5. What is your age?

I am ..... Years old



6. Do you have any dependants?  
By dependants we mean whether you have primary responsibility for the care of a child (aged 16 and under), for the care of a person with a disability or for the care of an elderly person.

- Yes I do have dependants
- No I do not have dependants

7. Gender  
Male   
Female

8. Sexual Orientation  
I am gay or lesbian (homosexual)   
I am straight (heterosexual)   
I am bisexual   
Other (please specify)

.....  
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