CONFIDENTIAL

MULTI-AGENCY SAFEGUARDING VULNERABLE ADULT REFERRAL FORM

This form is only to be used when abuse of a vulnerable adult has been discovered, suspected or disclosed

Please complete this form with as much factual detail as possible and include any allegations that are made. This form might be used in future criminal or civil proceedings and accuracy is therefore vital.

Details about the Alleged Victim

Name:

Date of Birth: **Age:** **Gender:** ☐ Male ☐ Female

Address:

Telephone:

If currently not at address, where can the alleged victim be contacted?

Vulnerability: why is the person considered vulnerable?

☐ Mental Health ☐ Learning Disability ☐ Physical Disability/Frailty Temp Illness
☐ Dementia ☐ Older Person/Frailty Temp Illness ☐ Terminal Illness
☐ Visual Impairment ☐ Hearing Impairment ☐ Dual Sensory loss
☐ Vulnerable Adult/Head Injury/Aspergers /Autistic SD ☐ Substance Misuse

Additional information (if any):_____

GP, Care manager, Health worker (please include telephone number(s))

Ethnicity & Diversity:

White	☐ White British ☐ White Irish ☐ Any other White background ☐ Traveller of Irish Heritage ☐ Gypsy/Roma	**Mixed**	☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Any other Mixed background
Asian or Asian British	☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Any other Asian background_____	**Black or Black British**	☐ Caribbean ☐ African ☐ Any other Black background _____
Other Ethnic Groups	☐ Chinese ☐ Any other ethnic group:	**Not stated**	☐ Refused ☐ Information not yet obtained

Any other relevant diversity issues (e.g. religion, sexuality):

Who is making the alert:

Name: **Relationship to the alleged victim?**

Address:

Telephone:

Preferred means of contact:

Who is filling in this form?

Is the alleged victim aware that this alert has been raised? ☐ Yes ☐ No

Is their next of kin/family carer aware this alert has been raised? ☐ Yes ☐ No

Details of suspect:

Name: **Relationship to the alleged victim?**

Address (if different):

Is this person a family/main carer (if known. i.e. not care staff)? ☐ Yes ☐ No

Nature of the Allegation:

Where the alleged abuse took place:		
☐ Own Home	☐ Alleged Perpetrators Home	☐ Supported Accommodation
☐ Care Home	☐ Care Home with Nursing	☐ Respite/Short-term break Home
☐ Hospital	☐ Mental Health Inpatient Setting	☐ Other Health Setting
☐ Day Centre/Service	☐ Education/Workplace/Training Est.	☐ Custodial situation
☐ Public Place	☐ Other (Please state below:)	☐ Not Known
	_____	
NAME OF ESTABLISHMENT (if applicable)		
Date alleged abuse took place:	**Time:**	
Type of abuse (tick box) ☐ Physical ☐ Sexual ☐ Neglect ☐ Institutional ☐ Financial ☐ Psychological & Emotional ☐ Discriminatory		
Brief details of what has been alleged to have taken place:		
Is domestic violence/abuse suspected?	☐ Yes ☐ No	
Are there any child safeguarding issues?	☐ Yes ☐ No	
Signature:	**Print Name:**	
Date:	**Time:**	

Form sent to: ☐ Adult Services ☐ Wiltshire Police ☐ Mental Health Services ☐ Hospital Social Work team

To be completed by Investigating Manager

Team receiving alert:	Case number (SWIFT/Care first / VAU):	
Date Alert received:	Time alert received:	
Person known to adult services:	☐ Yes	☐ No
Person receiving services prior to alert:	☐ Yes	☐ No
Person funds their own care:	☐ Yes	☐ No
Person in receipt of direct payment:	☐ Yes	☐ No
Person placed by another authority/trust:	☐ Yes Name of LA/trust:	☐ No
ALERT ASSESSED OUTCOME:		
Early Strategy Meeting Date (if any):_____ State reason if no ESM required: Information recorded on case records:	☐ Yes	☐ No
Decision made by: Signed:	Date:	Designation

Phone the referral to one of the following & fax/ send the form to confirm (keeping a copy for the Health Care Records:

In Hours: **SFT Hospital Social Work Dept ext 2400 Fax 01722 410939**

OOHs: **Wiltshire Council Emergency Duty Service 0845 6070888**
Wiltshire Police 101