**Logo, company name

Description automatically generatedReferral Form: NRM Reach-In Service**

This form should be completed **by the client with their current support provider or referrer.**

*Please be advised that the questions asked are not to determine suitability of Reach-In accessibility, but to ensure that the correct level of support is offered by the Reach-In provider.*

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| --- | --- | --- | --- | --- | --- | --- |
| Any urgent needs identified? | Destitution |  | Leave expires within 2 weeks |  | Immediate danger |  |

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| Name |  | | | | | | | | | | | | | | | | | | | | | | | |
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| Date of Birth  (DD-MM-YYYY) |  | | - | |  | | | - |  | Gender | | |  | | | | | | | | | | | |
|  |  | |  | |  | | |  |  |  | | |  | | | | | | | | | | | |
| Nationality |  | | | | | | | | | | | | | | | | | | | | | | | |
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| Language(s) spoken |  | | | | | | | | | | | | | | | | | | | | | | | |
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| Address |  | | | | | | | | | | | | | | | | | | | | | | | |
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| Contact Number | 0 | | | | | | |  |  | |  | | | | | | | | | | | | | |
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| +CG decision date  (DD-MM-YYYY) |  | | - | |  | | | - |  | NRM/Move-On exit date  (DD-MM-YYYY) | |  | | | - |  | - | |  | | | | | |
|  |  | |  | |  | | |  |  |  | |  | | |  |  |  | |  | | | | | |
| NRM Unique ID and SU ID |  | | | | | | | | | | |  | | | | | | | | | | | | |
|  |  | | | | | | | | | | |  | | | | | | | | | |  | | |
| Immigration status |  | | | | | | | | | | | Right to work (Y/N) | | | | | | | | | |  | | |
|  |  | | | | | |  | | | | |  | | | | | | | | | |  | | |
| Survivor journey / brief background since Move-On. |  | | | | | | | | | | | | | | | | | | | | | | | |
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| Current support received by other agencies (if relevant) |  | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | |  | | | | | | | | | | | | | | | | | |  | | |
| Number of dependent children |  | | |  | | | | | | | | | | | | | | | | |  |  | | |
|  |  | | |  | | | |  | | | | | | | | | | | | |  |  | | |
| Name(s) and age(s) (use continuation page if necessary) |  | | | | | | | | | | | | | | | | | | | |  |  | | |
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|  | | |  | | | | | | | | | | | | | | |  | | Please tick if support required | | | | | |
| Type of Support Required | | Medical treatment; | | | | | | | | | | | | | | | | |  |  | | | | | |
| Translation and interpretation; | | | | | | | | | | | | | | | | |  |  | | | | | |
| Assistance at appropriate stages of criminal proceedings against offenders; | | | | | | | | | | | | | | | | |  |  | | | | | |
| Education (whether for Dependent School Age Children or otherwise); | | | | | | | | | | | | | | | | |  |  | | | | | |
| Employment (including preparation for work); | | | | | | | | | | | | | | | | |  |  | | | | | |
| Mental health services | | | | | | | | | | | | | | | | |  |  | | | | | |
| Housing | | | | | | | | | | | | | | | | |  |  | | | | | |
| Substance dependency (detoxification) services; | | | | | | | | | | | | | | | | |  |  | | | | | |
| Sexual health services; | | | | | | | | | | | | | | | | |  |  | | | | | |
| Specialist counselling; | | | | | | | | | | | | | | | | |  |  | | | | | |
| Birthing partners; | | | | | | | | | | | | | | | | |  |  | | | | | |
| Resettlement support; | | | | | | | | | | | | | | | | |  |  | | | | | |
| ESOL classes; | | | | | | | | | | | | | | | | |  |  | | | | | |
| Support with submitting claims e.g. asylum, benefits, or legal | | | | | | | | | | | | | | | | |  |  | | | | | |
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| Level of spoken English/ Interpreter required? If so, which language? | | |  | | | | | | | | | | | | | | | | | | | | | |
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| Type of accommodation (eg NASS) if client has accommodation support needs | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | |
| Children’s school(s) (if applicable) | | |  | | | | | | | | | | | | | | | | | | | | | |
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| Income type (benefits; NASS or employment) if the client has financial support needs. | | |  | | | | | | | | | | | | | | | | | | | | | |
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| If in work, employment details if the client has employment support needs. | | |  | | | | | | | | | | | | | | | | | | | | | |
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| Police contact  (if applicable) if the client has criminal support needs | | |  | | | | | | | | | | | | | | | | | | | | | |
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| Social Care Services contact (if applicable) if the client has care support needs. | | |  | | | | | | | | | | | | | | | | | | | | | |
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| GP details (if applicable) | | |  | | | | | | | | | | | | | | | | | | | | | |
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| Ongoing medical treatment (incl. allergies, EpiPen etc) | | |  | | | | | | | | | | | | | | | | | | | | | |
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| Receiving support for drug/alcohol use (Y/N) | | |  | | | | *This will not impact eligibility but is to ensure the correct support can be provided* | | | | | | | | | | | | | | | |
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| If yes, please provide details if the client has medical support needs. | | |  | | | | | | | | | | | | | | | | | | | | | |
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| Legal contact (if applicable) | | |  | | | | | | | | | | | | | | | | | | | | | |
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| Any appointments due (legal; police; HO; court) | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | |
| Criminal record / PNC/ NEU-ECR (Y/N) and brief summary | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | *This may not impact eligibility but is to ensure the correct support can be provide* | | | | | | | | | | | | | | | | | | | | | |
| Ongoing medical treatment (incl. allergies, EpiPen etc) | | |  | | | | | | | | | | | | | | | | | | | | | |
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| Is there anywhere in the surrounding area that you, the Service User would not feel safe to visit? *(may be applicable if there will be a meeting in the community with the Reach-In support worker)* | | | | | | | | | | | | | | | | | | | | | | | | |
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| Any other comments / concerns (use separate sheet if necessary) | | | | | | | | | | | | | | | | | | | | | | | | |
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**Client consent to share information with** ………………………………………………………………………………………………….…………………………

I, ……………………………………………………………………………………………………………………………………………………………… hereby consent for my referrer, ……………………………………………………………………………………………………………………………………………… to share information on my file with ……………………………………………………..……………………… for the purposes of completing referral for reach-in support.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Signature |  | Date |  |
|  |

**Referrer Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | Contact No | |  |
|  |  | |  |  |
| Email address |  | | | |
|  |  | | | |
| Referrer/agency |  | | | |
| Please return to [mstsupport@salvationarmy.org.uk](mailto:mstsupport@salvationarmy.org.uk) | | | | | |

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[*https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms/privacy-information-notice-national-referral-mechanism*](https://protect-eu.mimecast.com/s/gOmlC66n0uG6v4Js6ClaZ?domain=gov.uk)