SUPPORTED LIVING REFERRAL FORM

Complete all applicable sections; confidential care information — return only via a secure approved

Please complete in BLOCK CAPITALS where practical. If a question does not apply, write N/A and explain where necessary. You may attach a separate sheet. Do not submit this completed form using ordinary unencrypted email.

Privacy: refer to Lyriq Healthcare's approved privacy notice for lawful processing, access, data sharing and retention. The original paper form referred to information sharing with relevant housing, local authority and professional bodies; any disclosure must be lawful and appropriate.

01 REFERRAL SOURCE

Date of referral (DD/MM/YYYY)

Organisation / agency name

Referral source first name

Referral source last name

Referral source contact name (if different)

Referrer email address

Referrer full postal address

Referrer telephone number

02 CLIENT INFORMATION

Client first name

SUPPORTED LIVING REFERRAL FORM

Complete all applicable sections; confidential care information — return only via a secure approved

Client middle name

Client surname

Gender (male / female / other / prefer to describe)

Preferred pronouns (optional)

Date of birth (DD/MM/YYYY)

Diagnosis — physical and/or mental health (as relevant)

Client full address

Client telephone number

Client email address

Ethnicity (optional)

Languages spoken (optional)

SUPPORTED LIVING REFERRAL FORM

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Emergency contact name

Emergency contact telephone number

03 REFERRAL REASON & SUPPORT NEEDS

Reason for referral to Supported Living services

Client primary support needs (select all that apply)

- ☐ Mobility
- ☐ Personal care
- ☐ Medication
- ☐ Behavioural support
- ☐ Social integration
- ☐ Mental health
- ☐ Other

Other support needs — please specify

Currently receiving other services?

- ☐ No
- ☐ Yes

If yes, provider(s), service type and details

04 MEDICAL & HEALTH INFORMATION

SUPPORTED LIVING REFERRAL FORM

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Primary health conditions / disabilities

Medications currently prescribed

Known allergies

Primary Care Physician / GP — name and contact details

Other professionals involved (specialists, therapists, social worker, LMHT etc.)

05 RISK ASSESSMENT

Identified risks (select all that apply)

- ☐ Self-harm
- ☐ Harm to others
- ☐ Substance abuse
- ☐ Exploitation
- ☐ Arson
- ☐ Aggression
- ☐ Other
- ☐ None known

SUPPORTED LIVING REFERRAL FORM

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Other identified risk — specify

Risk details and measures currently used to manage risks

06 PREFERENCES, GOALS & ADDITIONAL INFORMATION

Preferences for supported living (location, type of support, cultural needs)

Goals and aspirations (independence, community, employment and other goals)

Additional relevant information or documentation

SUPPORTED LIVING REFERRAL FORM

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07 REFERRER DECLARATION

I confirm that the information provided is accurate to the best of my knowledge. I understand that further information may be needed and will cooperate appropriately. I have the appropriate authority to share the information supplied.

Referrer full name / signature

Declaration date (DD/MM/YYYY)

08 FOR LYRIQ STAFF USE ONLY

Referral received by — staff name

Assessment date (DD/MM/YYYY)

Referral outcome — Approved / Declined / Pending

Assessment notes and next steps

Additional notes / continuation sheet