Appendix 3

Multi-agency Adult Support & Protection/Adult Concern Referral Form (APR)			
Adult Support & Protection Referral		Adult Concern Referral	

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

3 POINT TEST (CRITERIA) To the best of your knowledge is:

The Adult is affected by disability, mental disorder, illness or physical or mental infirmity (if yes, please specify) **YES or NO**	
The Adult is **unable** to safeguard their own wellbeing, property, rights or other interests - **YES or NO**	
The Adult is at risk of harm (if yes, please state reason and type of harm) - **YES or NO**	

If you have answered yes to all of the above questions, please tick Adult Protection Referral.
If you have not answered yes to all of the above questions, please tick Adult Concern Referral

DETAILS OF HARM (suspected/witnessed/disclosed/reported) Include details of any previous AP Referrals/Concerns if known and any action taken to protect the adult by the referrer. (please use separate sheet provided if required)

Date of Incident	**Day of Incident**	**Time of Incident**

ADULT DETAILS	**please PRINT details, thank you**

Name:	**DOB:**
New Address:	**Current Whereabouts:**
Postcode:	**Telephone No.**
Mobile:	**CHI/Social Work Reference No (if known)**

Gender	Choose an item.	**Ethnicity**	Choose an item.	**Religion**	Choose an item.

Is the adult aware of this referral? **YES / NO** (delete as appropriate) If **NO** please state reasons
Is it suspected that a crime has been committed and have Police Scotland been informed? (Include date/time contact made, who contacted police, known action taken, incident number etc.)

Communication Support (Please provide details including communication aids needed by the adult e.g. hearing aid, interpreter, Makaton etc.)

Is Advocacy Support in Place?	**Yes**		**No**	
Advocacy Support **If no – would a referral be appropriate?**	**Yes**		No	

Advocacy Support (If yes, 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/adults that the adult at risk may be responsible for)	

DETAILS OF PERSON REPORTED TO BE CAUSING ALLEGED HARM (If known)
Please PRINT details

Name		**Relationship to adult**	
Current address		**Telephone No.**	

REFERRER DETAILS **Please PRINT details, thank you**

Name		**Designation**	
Agency		**Department**	
Direct Dial No		**E-mail**	
Relationship to adult referred		**Date of referral**	

REFERRAL FORM TO BE SENT WITHIN 24 HOURS OF IDENTIFYING A CONCERN TO

East Ayrshire Health & Social Care Partnership	HSCPCustomerFirst@east-ayrshire.gov.uk
North Ayrshire Health & Social Care Partnership	adultprotection@north-ayrshire.gov.uk
South Ayrshire Health & Social Care Partnership	ASP@south-ayrshire.gov.uk
For assistance out of hours contact:	**0800 328 7758**

PLEASE ALSO SEND A **COPY** TO THE ASP HEALTH TEAM
aa.clinicalASPhealth@aapct.scot.nhs.uk

Remember – An ASP Referral does not provide an emergency response – ifnecessary, phone 999 to access immediate assistance