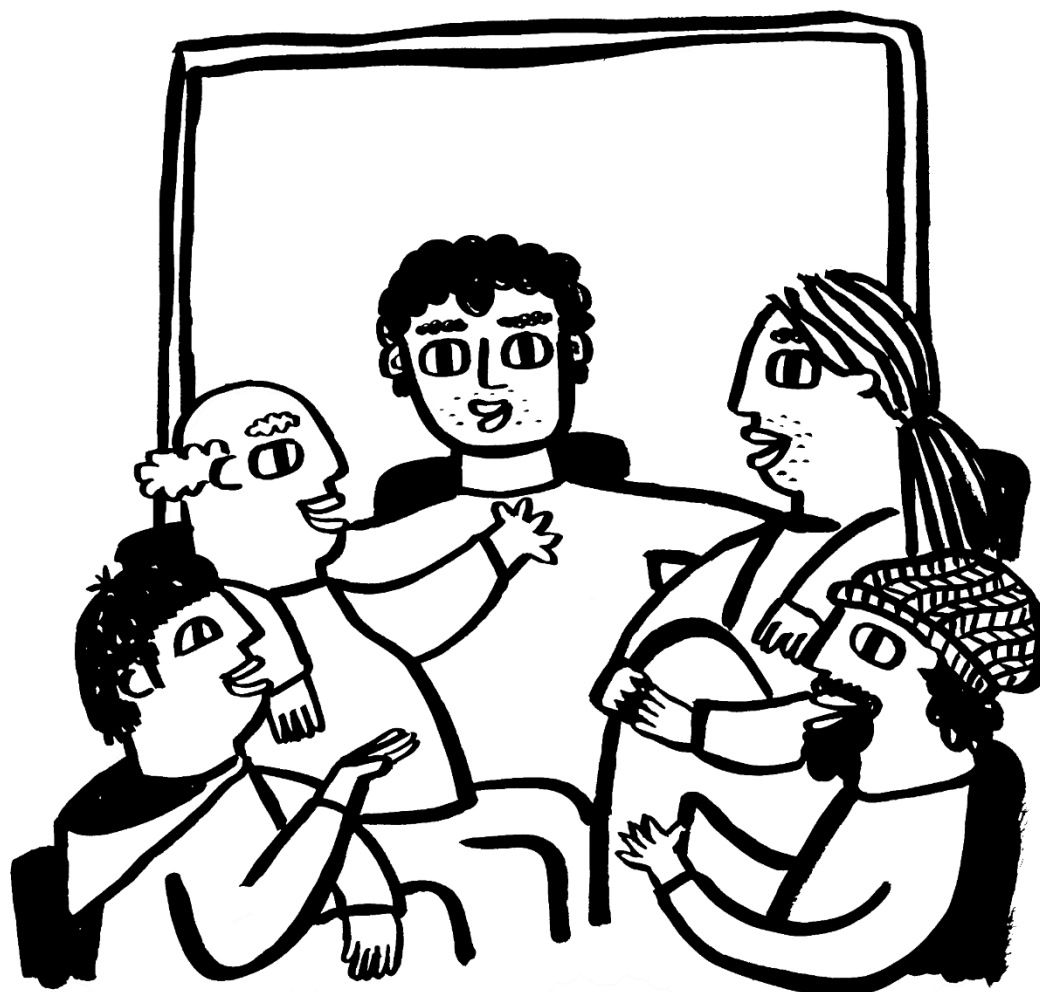


SCT Acorn House Referral Form

Please read this pack carefully and complete each section in full.

Name of Applicant	
Referral Date	

Please send the completed referral form to referrals@sct.org.uk. The application will be assessed and you will be contacted about next steps



Spitalfields Crypt Trust
 Acorn House, 116-118 Shoreditch High Street, London, E1 6JN
 Registered charity No. 1075947
 Company No. 3734793
 0207 613 5677

Referral Details

Agency referring	
Name of referral worker	
Referral contact details (telephone, email, address, borough)	

Source of referral (please tick)			
Voluntary agency		Statutory agency	
Other (please state):			

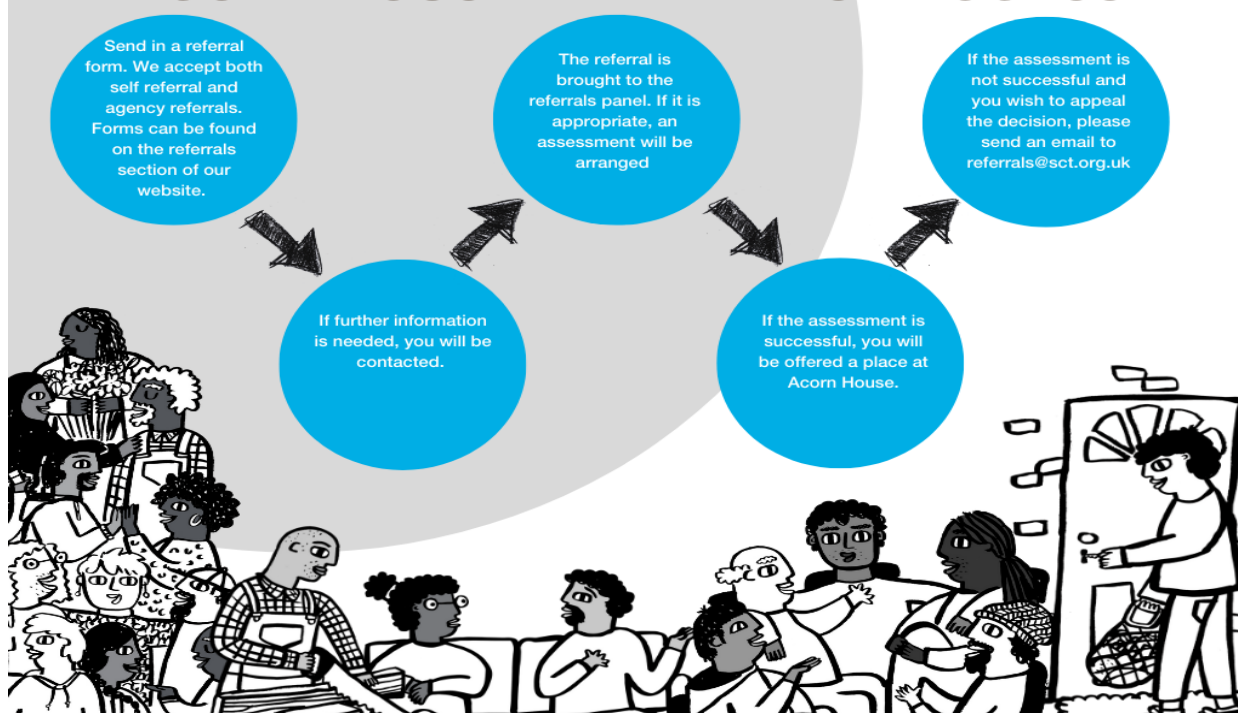
How long have you known the applicant?	
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About Acorn House

Acorn House is a residential rehabilitation centre for men struggling with homelessness and addiction. It is an abstinence-based service and residents are tested regularly. If a test shows positive for alcohol or any substance, we will endeavour to ensure a resident has alternative accommodation and they will be required to leave. Because of this, we have restrictions on the medication residents can take whilst in Acorn House. We do not accept applicants on a methadone or Subutex script, or any other opiate based medication. However, if there is a detox plan or a scheduled detox, we would welcome the referral and work with the detox coordinator to ensure a smooth transition into Acorn House. Acorn House is funded by housing benefit, meaning that residents need to be eligible for benefits. Support workers will work with the residents to apply for HB and any other benefits they may be eligible for. There is a weekly service charge that residents are expected to pay. Residents cannot work whilst participating in the acorn house programme. Residents are expected to participate in the upkeep of the house. The Acorn House programme consists of:

- Group counselling sessions three times a week
- One-to-one counselling sessions once a week
- One-to-one keywork sessions once a week
- Daily morning reflections
- Training and Development classes twice a week
- An in-house AA/NA meeting once a week. There is a further expectation that residents attend at least 4 AA/NA meetings each week.

ACORN HOUSE REFERRALS PROCESS



Acorn House Referral Criteria

Is the applicant:	Yes	No
Are you able to participate and engage in the programme at Acorn House?		
Are you able to walk up and down stairs unaided?		
Are you able to ask for help when you need it?		
Are you willing to pay a weekly service charge?		
Are you able to share with people from a variety of backgrounds, ages, sexual orientations, races, colours, cultures, and abilities?		
Are you eligible for welfare benefits?		
Do you currently have a tenancy?		
Are you able to manage your own prescribed medication (with support)?		

Personal Details

First name	
Surname	
Age	
Date of birth	/ /
Place of birth (town and country)	
Next of Kin / Emergency Contact Name	
Next of Kin / Emergency Contact Phone Number	
Please confirm you are happy for us to contact your emergency contact in situations where we feel it is appropriate.	Yes <input type="checkbox"/> No <input type="checkbox"/>

<i>Gender (please tick)</i>			
Male	<input type="checkbox"/>	Non-binary	<input type="checkbox"/>
Female	<input type="checkbox"/>	Other (please state below):	
Transgender	<input type="checkbox"/>		

Nationality			
Have you been in the armed forces?	Yes	<input type="checkbox"/>	No

<i>Faith & Religion (please tick)</i>			
Christian	<input type="checkbox"/>	Muslim	<input type="checkbox"/>
Buddhist	<input type="checkbox"/>	Sikh	<input type="checkbox"/>
Hindu	<input type="checkbox"/>	None	<input type="checkbox"/>
Jewish	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>
Other			

Ethnic Origin (please tick)

<i>White</i>			
English	<input type="checkbox"/>	Irish	<input type="checkbox"/>
Welsh	<input type="checkbox"/>	Traveller	<input type="checkbox"/>
Scottish	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>
Northern Irish	<input type="checkbox"/>	Any other white background (please state below)	
British	<input type="checkbox"/>		

<i>Black/African/Caribbean/Black British</i>			
African	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>
Caribbean	<input type="checkbox"/>	Any other black/African/Caribbean /Black British background (please state below)	

<i>Mixed/Multiple Ethnic Groups</i>			
White and Black Caribbean	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>
White and Black African	<input type="checkbox"/>	Any other mixed background (please state below)	
White and Asian	<input type="checkbox"/>		

<i>Asian</i>			
Indian	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>
Pakistani	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
		Any other Asian background (please state below)	

<i>Other</i>		
Arab	<input type="checkbox"/>	Any other ethnic background (please state below)
Prefer not to say	<input type="checkbox"/>	

Accommodation Details

Where are you currently staying?			
How long have you been staying there?			
Do you have a history of homelessness?	Yes		No
Do you have a chain number?			

Contact Details

Address (if no fixed abode, please state)	
If you are sleeping rough, please provide alternate ways of contacting you:	
Borough:	
Postcode	
Mobile:	
Email	

Family and Relationships

Your relationship status:			
Do you have children?	Yes		No
If yes, how many do you have, and how old are they?			

Health

Do you have a disability?	Yes		No
If yes, what kind of disability do you have?			
Do you have any physical health issues?	Yes		No
What are they, and when were you diagnosed?			
Are you receiving any professional support or treatment for managing your physical health issue/s?			

Do you have any diagnosed mental health issues? If so, what are they? (please tick)

Anxiety	<input type="checkbox"/>	Bipolar disorder	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>
Personality disorder (please specify below)	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>
None	<input type="checkbox"/>		

Other (please state below):	<input type="checkbox"/>

When were you diagnosed with your mental health issue/s? (please state each mental health issue and the date diagnosed by a medical professional)

Were you in active addiction when you were diagnosed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Are you receiving any professional support or treatment for managing your mental health issue/s?

CPN	<input type="checkbox"/>	GP	<input type="checkbox"/>
Psychiatrist	<input type="checkbox"/>	Other	<input type="checkbox"/>
None	<input type="checkbox"/>		

Psychiatrist and/or CPN details (if applicable)

How does your mental health affect you?

Have you been admitted to a psychiatric hospital? If so, please provide details:

What medication are you currently taking? Please tell us quantities and what each medication is for:

Finances

What regular income do you have?

ESA – contribution-based		ESA – income-related	
Full-time employment		Housing benefit	
JSA – contribution-based		JSA – income-based	
Part-time employment		Personal Independence Payment	
Private pension		Savings	
State pension		Universal Credit	
Other (please state)			

Do you have any debt?	Yes		No	
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If you do have debt or rent arrears, how much is it, and who are you in debt to?

What is your National Insurance number?	
---	--

Criminal Justice System

If you have made any court appearances or been given a prison sentence in the last 10 years, please provide details, including the charge, outcome, and details of terms:

--

If you have any outstanding court orders, probation and fines, or statutory orders, please provide further details:

--

Probation officer's name and contact details (if applicable)

--

Addiction

Please tick all which apply. Please identify which is your primary addiction by marking it "P".

Substance

Alcohol		Amphetamines	
Cannabis		Cocaine (crack)	
Cocaine (powder)		Crystal meth	
Ecstasy		GHB	
Heroin		Ketamine	
Legal highs		LSD	
Other opioids		Spice	
Prescription drugs		Other	

Behaviours

Computer games		Exercise/gym	
Gambling		Phone	
Pornography		Sex	
Other (please state)			

If you are on a prescription for Methadone or Subutex, what quantity are you prescribed?
Do you have a proposed detox/reduction plan? If so, what are the details?

When did you last drink alcohol or use drugs?

What are you currently using/drinking?

If you have been in a rehabilitation or treatment programme, where was it, and how long did it last? Please give us all the details you know:

Risk Assessment

We will not accept referral forms without a completed risk assessment

IMPORTANT: This section must be completed by a referral agency. Please use the following definitions to answer the questions:

NONE	No incidents
LOW	Isolated or occasional incidents of non-significance or a low potential of incidents occurring or recurring
MEDIUM	Regular incidents
HIGH	Likely, severe, or significant incidents

A) Does the applicant have a history/is there a risk of any of the following violent offences/incidents towards others:

Category	NONE	LOW	MEDIUM	HIGH	If identified, please comment
Physical violence					
Psychological abuse					
Sexual abuse					
Racial abuse					
Verbal abuse					
Damage to property/arson					

B) Is there a history of difficulties regarding previous tenancies?

Category	NONE	LOW	MEDIUM	HIGH	If identified, please comment
Rent arrears					
Disputes					
ASB					
Evictions					

Harassment					
Non-engagement with support/other					

C) Is there a history of, or a risk of any of the following?

Category	NONE	LOW	MEDIUM	HIGH	If identified, please comment
Suicide or self-harm					
Accidental overdose					
Abuse to others					
Vulnerability – abuse from others					
Mental health					

D) Please describe any other potential risk:

--

E) Further information:

(If you're self-referring, you can ignore this bit)

Please state how long you have known the applicant	
Has the applicant ever been refused support? If yes, please state why?	
Please provide any other relevant information	

Declaration

I confirm that the information contained in this document is true and accurate to the best of my knowledge and includes all relevant information required to assess my referral correctly:

Applicant

Signed: _____

Name printed: _____

Date: _____

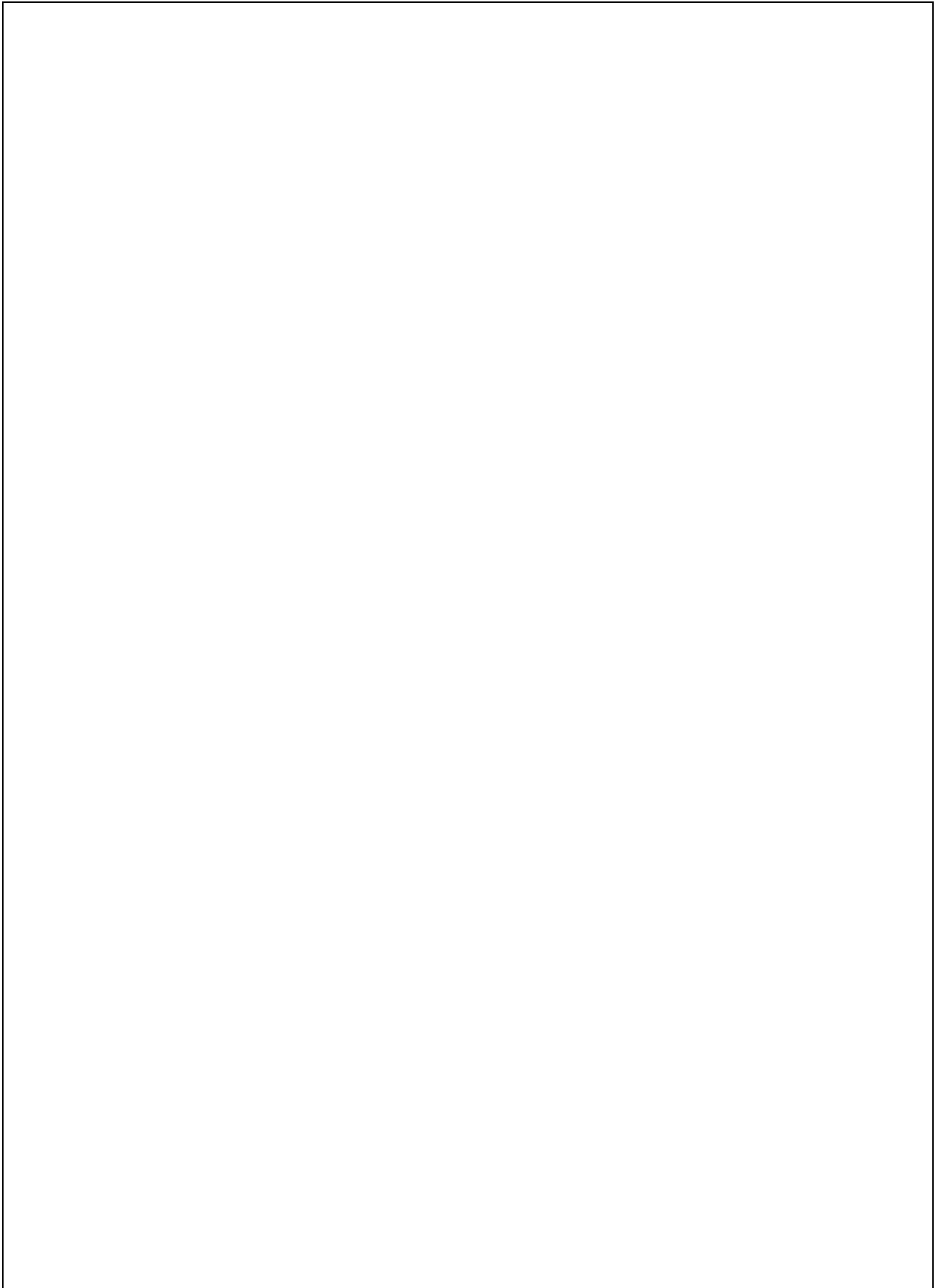
Referral Agency (if applicable)

Signed: _____

Name printed: _____

Date: _____

Notes

A large, empty rectangular box with a thin black border occupies the central portion of the page. This box is intended for providing detailed information during a referral process.