## Housing Referral Form Under The Homelessness Reduction Act 2017

English public authorities are required to notify people who they think are homeless, or may be at risk of homelessness in the next 56 days, to a local housing authority (LHA). Follow your local protocol for referral, but consent must be obtained and the person is entitled to choose which LHA is notified.

### Consent to release information: (to be signed by the person referred)

|  |
| --- |
| I agree for information on this form to be released to my local housing authority for the purpose of obtaining advice regarding my housing need.  Signed:       Date: |

### Referrer details

|  |  |
| --- | --- |
| Patient location (e.g. ward): |  |
| Name and contact details of referrer: |  |

### Details of person referred

|  |  |  |  |
| --- | --- | --- | --- |
| Family name |  | Title: |  |
| Forename |  | Gender: |  |
| Preferred name |  | DOB: |  |
| Nationality |  | Is an interpreter required? | Yes |
| Preferred language |  | No |

### Accommodation

|  |  |  |  |
| --- | --- | --- | --- |
| Current address: (if applicable) | Home tel: | |  |
| Mobile: | |  |
| Email: | |  |
| Postcode: | Borough: | |  |
| Has the person lived at this address for more than 6 months?  If NO, please give all addresses in the last 5 years, continue on a separate sheet if needed | | | |
| Current accommodation type: (tick most appropriate) | | | |
| Owner occupier | | Private rented | |
| Council tenant | | Sleeping rough | |
| Living with parents | | Night shelter | |
| Staying with other family/friends | | Hostel | |
| Housing Association (please specify) | | Other (Please specify): | |

### Employment status and benefits

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| --- |
| Is the patient in employment? Please give details: |
| Is the patient in receipt of any benefits?  Yes  No |
| Which benefits does the patient get? Please specify including any DLA payments: |

### Does the person have any links to the LHA you are notifying? Please mark all relevant boxes

|  |  |  |
| --- | --- | --- |
| Currently resident | Previously resident | Care leaver in the area |
| Employed in the area | Parent or sibling in area | |
| Other family association (please describe) | | |
| Rough sleeping in the area (please give location) | | |
| Other (please explain) | | |

### Medical information

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| Please list all medical diagnoses, social difficulties and mobility problems, and whether they are likely to be long or short term. Please include any mental health and substance misuse issues. |
| What date is the patient due to be discharged? |

### Aids and adaptations/facilities

|  |  |  |  |
| --- | --- | --- | --- |
| Is the Hospital OT involved?  No  Yes  Name and contact details: | | | |
| OT assessment recommended (please mark all that apply) | | | |
| Stair lift | Hoist | Through floor lift | Wetroom |
| Ramp | Remote opening | Hand rails/ grab rails |  |
| On return to home without appropriate facilities, will there be serious risk to health of or accident to the person or the carer? (please give details) | | | |
| Without necessary or appropriate facilities will the needs of this person be affected long term?  Yes  No | | | |
| Will the patient’s long term ability to stay at home be compromised without aids/adaptations/facilities?  Unlikely  Possible  Likely  Probable  Definite | | | |

### Reason why the client cannot return to current or last accommodation

|  |
| --- |
| For example ‘current accommodation is unsuitable’, ‘the patient is homeless upon discharge’: |