# REFERRAL FORM

**COMMUNITY SOCIAL WORK SERVICE at Ċentru Antida family support services hub**

Generic social work services are provided to vulnerable individuals and families living in Tarxien, Paola, Fgura, Santa Luċija and Birżebbuġia. Prior to completing the referral form, a case consultation is to be held with professionals from the foundation.

**The Filled-in referral forms has to be sent via email on** **socialwork@antidemalta.org**

### Section A: Details of Referrer and other professionals involved

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Referral:**  | Click here to enter a date. | **Referring Agency:** | Click here to enter text. |
| **Service Unit:** | Click here to enter text. | **Profession/ designation:** | Click here to enter text. |
|  |
| **Name of Referrer:**  | Click here to enter text. | **Warrant No** **(If applicable):** | Click here to enter text. |
| **Direct Telephone/s Nos:**  | Click here to enter text. | **E-mail address:**  | Click here to enter text. |

**Details of other Professionals involved with the person/ family being referred**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name & surname** | **Designation** | **Organisation** | **email** | **Tel. No.** | **Supports which referred person?** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

### Section B: Service User’s Details

**Details of main person being referred**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name**  | Click here to enter text. | **Surname** | Click here to enter text. |
| **ID Number** | Click here to enter text. | **Date of Birth** | Click here to enter text. |
| **Gender**  | Click here to enter text. | **Nationality** | Click here to enter text. |
| **Email** | Click here to enter text. | **Mobile/Telephone number** | Click here to enter text. |
| **Address 1** | Click here to enter text. | **Address 2- Locality** | Click here to enter text. |
| **Number of adults in need of support (excluding the main person referred)** | **Male**  | **Female**  | **Other** | **Number of minors in need of support (excluding the main person referred)** | **Male**  | **Female** | **Other** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Language Preferred**  | Click here to enter text. | **Citizenship/immigration status** | Click here to enter text. |

**Next of Kin/Emergency Contact:**

|  |  |
| --- | --- |
| **Name and Surname:**  | Click here to enter text. |
| **Relation:**  | Click here to enter text. |
| **Contact details ils**  | Click here to enter text. |

**Status:**

 Single Married Widow/er

 Divorced Separated Cohabiting

**Is the service user referred aware of referral:** Yes No Not Yet

**Family Composition and Significant Others (Excluding main person referred):**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name & surname** | **Address** | **Relation** | **Mobile/ Telephone** | **ID No:** | **Date of Birth** | **Comment: (ex. employment; relationship; mental health; other)** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
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### Section C: Presenting Problem

**Presenting Problems According to the Service User:**

**Presenting Problems According to the Service User (at this stage please select only one):**

 Abuse in Intimate Relationships Caregivers of Mentally Ill Persons Emotional Distress

 Family Dynamics Financial Difficulties Ill Health and Frailty

 Homelessness and Substandard Housing Other [please specify]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Reason for referral according to the referrer:**

**(Information re health, support network, social workers comments etc):**

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|  |

**Reason for referral according to the service user- If different from that of the referrer:**

**(Information re health, support network, social workers comments etc):**

**Description of service user’s present situation, including the service user’s perspective:**

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**Genogram:**

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**ECO-map:**

**Details on interventions already carried out:**

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**Other essential information:**

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 Signature of Referrer Date

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