

Dear Referrer

You have concerns for an adult.

You can use the attached APR referral form to convey your concerns to the relevant Health and Social Care Partnership, in your area of Ayrshire.

If you think that the adult for whom you have concerns meets the 3 Point Test (criteria) for a referral under the Adult Support and Protection legislation), you will have answered yes to all 3 mandatory questions about them being unable to safeguard, being at risk of harm and having an illness or disability which makes them vulnerable. When all 3 of these questions have been answered 'yes' your referral will be treated as a formal Adult Support and Protection referral. The Adult Support and Protection legislation provides protection for having shared information about the adult because of your concerns and your belief that they might meet the criteria. You do not require the adult's consent to make an Adult Support and Protection referral. If you are a member of staff, you will receive feedback in relation to any ASP referral which you make.

If you have answered 'no' to any of the mandatory questions in the 3 Point Test (criteria) about them being unable to safeguard, being at risk of harm and having an illness or disability which makes them vulnerable, your report will be treated as an Adult Concern referral and will not fall under the remit of the Adult Support and Protection legislation (unless further information comes to the attention of the Health and Social Care Partnership, which suggests that the referral should be upgraded to a formal Adult Support and Protection Referral). When making an Adult Concern referral, you should adhere to Data Protection Legislation Guidance on information sharing. Ensure that the information you pass on is adequate, relevant and limited to what is necessary to share your concern for the adult. You will not receive feedback from the submission of Concern Reports. Ideally, the adult will provide their agreement for a referral where they do not meet the Adult Support and Protection 3 Point Test (criteria), however, provided you have considered the circumstances and believe that the information should be passed to the Health and Social Care Partnership and this information is adequate, relevant and limited to what is necessary, you should go ahead and make the referral.

Please note that feedback in relation to ASP referrals is provided for all staff of agencies/organisations. However, we do not provide feedback to members of the public or for any concern reports submitted.

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

Adult Support & Protection Referral		Adult Concern Referral	
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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)

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Date of Incident	Day of Incident	Time of Incident
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ADULT DETAILS

please PRINT details, thank you

Name:	DOB:
Home 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.
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Is the adult aware of this referral? **YES / NO** (delete as appropriate) If **NO** please state reasons

Have the Care Inspectorate been notified (where required) YES/NO/NA (delete as appropriate)

Who else has been notified of this Referral? (Power of Attorney or Guardian, Next of Kin, Family Member) Please state below:

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

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

Additional Information

(Please record any additional information here: