HIGHLAND ADULT CONCERN REFERRAL FORM

Highland Adult Protection Committee

Adult's Details

Name of Adult		**Date of Birth / Age**	
Home Address			
		Postcode	
Telephone number(s)			
Current Address (if different)			
Telephone number(s)			
Gender		**Ethnicity**	
Religion		**First Language**	
Preferred method of communication		**Does the adult have any disability/mental disorder/medical condition**	**YES/NO**
If Yes, Please give details			

Please describe the issues which concern you. Please include information about how long or how frequently this has been happening and the impact on the adult, if known.

In your opinion, which of the following may apply (please tick any that apply)

Mental Health Concerns		**Learning Disability**	
Drug Consumption		**Alcohol consumption**	
Visual Impairment		**Hearing Impairment**	
Speech impairment		**Physical Injury/Impairment**	
Isolation		**Dementia**	
Suicidal ideas/attempts		**Financial**	
Self Harm		**Psychological Harm**	
Sexual Harm		**Neglect**	
Other (please describe)			

Please answer the following questions by inserting your opinion and reasons for it

Is the adult able to safeguard their own well-being, property, rights or other interests?	**YES/NO** State reason:
Is the adult at risk of harm?	**YES/NO** State reason:
Is the adult affected by disability, mental disorder, illness or physical or mental infirmity? (i.e. they are more vulnerable to being harmed than adults who are not so affected)	**YES/NO** State reason:

In your opinion, which form of harm is the adult experiencing (please tick any that apply)

Physical		**Financial**		**Exploitation**		**Self-harm**	
Emotional/ psychological		**Sexual**		**Neglect**		**Self - neglect**	
Organisational		**Other (please describe)**					

Consent to Share Information

Has consent been given to share information?	If no state the reason why:
Has consent been given to share information with GP?	If no state the reason why:

Other Significant Person/s if known

Name	Date of Birth	Gender	Address	Occupation	Relationship to Adult

Agency/Agencies Involved with the Adult

Agency			
Name of Agency Contact		**Contact Telephone Number**	
Nature of Agency involvement			

Details of GP

GP Name		**Contact Telephone Number**	
GP Address			
Health Issues or known medication			

Does the adult live with or care for children under the age of 16?	

Person Submitting Details

Name		**Date Submitted**	
Designation / Job Role *(if applicable)*			
Address			
Contact Telephone Number(s)			
Email address			
Does the adult know you have shared your concern?	**YES/NO**		

Please email the completed form to the adult's local health and social care team – see next page

HIGHLAND ADULT SOCIAL CARE TEAM CONTACTS

Area / District	Email	Phone
North		
Caithness	nhsh.caithness-sw-duty@nhs.scot	0345 850 9413
Sutherland	nhsh.sspoc@nhs.scot	01408 664018

West		
Skye, Lochalsh & Wester Ross	nhsh.singlepointofcontactSLWR@nhs.scot	01471 820174
Lochaber	nhsh.lochabersw@nhs.scot	01397 709832

Mid		
Mid Ross	nhsh.mrhscc@nhs.scot	01349 860460
East Ross	nhshighland.eric@nhs.scot	01349 853131

South		
Inverness East & West	nhsh.spoainvernesseastwest@nhs.scot	01463 888333
Nairn	Nhsh.nairnsocialwork@nhs.scot	01667 422702
Badenoch & Strathspey	nhsh.bandsspoa@nhs.scot	01479 812618

Transitions Team	nhsh.transitionsteam@nhs.scot *(For under 25 year olds in Mid & East Ross, Inverness, Badenoch & Strathspey and Nairn)*	01463 644325

Please note that if any of the details shown above should change after this document was produced, then the latest contact information for the Teams will be published on the NHS Highland ASP web-page.

Our web-page can also be accessed using nhsh.scot/ASP.