

## Veterans' Outreach Service Referral Form

Title		Surname		First Name	
Date of Birth				Gender	
Telephone Number				Ethnicity	
Date of Referral				N.I. Number	
Address:					
Do you have any communication needs? This could include language assistance? Please give details.					
<b>Armed Forces Service</b>					
Service, Branch, Corps or Regiment					
Rank		Service Number			
Date Enlisted		Discharge Date			
WIS (Wounded, Injured or Sick)	Going through Transition	General Outreach			
<b>Yes/No</b>	<b>Yes/No</b>	<b>Yes/No</b>			
<b>Next of Kin/Emergency Contact Details:</b>					
Name				Telephone Number	
<b>GP Details</b>					
Name of GP			Telephone		
Address of GP:					
<b>Please list other agencies you are working with: (social worker, carer, CPN etc)</b>					
Name	Agency	Contact Details	Can we contact them for information about you? <b>Yes/No</b>		

Type of Current Accommodation (X):			
<input type="checkbox"/>	Owner Occupied	<input type="checkbox"/>	Rented HA
<input type="checkbox"/>	Rented Council	<input type="checkbox"/>	Rented Privately
<input type="checkbox"/>	Homeless	<input type="checkbox"/>	Other please specify:
Brief outline of your current circumstances (e.g. health, mobility, ability to cope):			
Which of the support service outcomes below are you aiming to achieve? (X)			
<input type="checkbox"/>	Maximise income including applying for welfare benefits	<input type="checkbox"/>	Better manage substance misuse issues
<input type="checkbox"/>	Reducing debt	<input type="checkbox"/>	Access assistive technology/aids and adaptations
<input type="checkbox"/>	Obtain paid work	<input type="checkbox"/>	Access housing repairs
<input type="checkbox"/>	Participate in training or education	<input type="checkbox"/>	Access more appropriate accommodation
<input type="checkbox"/>	Participate in work-like activities, e.g. unpaid/voluntary work/work experience	<input type="checkbox"/>	Maintain accommodation and avoid eviction
<input type="checkbox"/>	Better manage physical health	<input type="checkbox"/>	Help comply with statutory orders in relation to offending behaviour
<input type="checkbox"/>	Better manage mental health	<input type="checkbox"/>	Avoid causing harm to others
<input type="checkbox"/>	Participate in informal learning activities	<input type="checkbox"/>	Minimise harm/risk of harm from others
<input type="checkbox"/>	Participate in leisure/cultural/faith activities	<input type="checkbox"/>	Develop confidence and ability to have greater choice and / or control and / or involvement
<input type="checkbox"/>	Establish contact with external services /groups /friends /family	<input type="checkbox"/>	Other;
If referral has been completed by a referring agency, please complete the following details.			
Referrer's Name		Organisation	
Referrer's Email		Telephone Number	
Address:		Date of referral	
		Signature of referrer:	
Is the client aware of the referral?			
Does the client have an understanding of the Floating Support Service?			
Client signature:			

Please note: We will need a photocopy of your service identity card (if still serving) or a copy of your discharge papers (if already left the service).

Please send completed referral forms, together with any relevant reports to:

**Veterans' Outreach Service  
Stoll  
446 Fulham Road  
London SW6 1DT  
outreach@stoll.org.uk**