**Homeless Person/Housing Concern: Example Checklist**

*For reception use only:*  
**Name:**

**Date of birth:** DD / MM / YYYY

**MRN Number:**

**NHS Number:**

**Ambulance Attendance:** Y N

**Place of safety concern:** Y N

**Registered with a GP:** Y N

*This example checklist is provided to be adapted*

*locally. Ensure that any final checklist is consistent*

*with local trust policy and relevant information*

*governance and legal requirements.*

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| **Section A – to be completed by Clinician and/or SPOC (if identified). Please tick appropriate boxes below:** | |
| 1. **Patient Location**   ED Urgent Care or please state/site or area……………………………………… | |
| 1. **What is the housing concern?** (Please tick all that apply) | |
| Rough Sleeping? | Temporary / Hostel Accommodation? |
| Staying with Family/Friend(s)? | Eviction – asked to leave current accommodation? |
| Abuse? (including Domestic, sexual, emotional and/or other) | Court eviction? |
| Human Trafficking? | Rent/mortgage arrears? |
| Unsafe / Over-crowded accommodation? | Other (please specify): |
| Any dependants? Y N Under the age of 18? Y N | |
| 1. **What type of accommodation are they currently living in?** | |
| Street Squat Hostel Rented Supportive Housing Temporary Housing  House of Friend or Family | |
| Other (please specify): | |
| 1. **Patient’s Details:** | |
| Patient phone number: | Patient email: |
| Patient current address/area: | |
| Patient alternative contact name/address (if different): | |
| 1. **What was the patient offered?** (Please tick all that apply): | |
| Clothing? Food and Water? Wash Facilities? Help registering with a GP?  Leaflet on local services Referal to Homeless Services?  Other (please specify): | |
| 1. Financial/Employment Details (tick all that apply): | |
| Works in Salaried Employement? Access to Benefits/Universal credit?  Keyworker contact details if known: …………………………………………………………….. | |
| 1. Does the patient consent to being refered via the Duty to Refer Form   Either confirm in writing of verbally that the patient understands that the Council may use this information in the form to contact them and to help assess their needs for assistance with housing.  Patient Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Staff Signed if received verbal consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. Can basic screening/vaccination be offered whilst Patient is waiting in ED?   Does the patient have any MH condition?  Yes No  If yes, is the patient able to access support services in the community?  ………………………………………………………………………………………….  Was a MH condition main reason for this attendance?  (Please link/detail local MH referral routes)  ………………………………………………………………………………    **Drug and alcohol misuse?**  Harmful drinking (*alcohol consumption causing health problems directly related to alcohol*)? …………………………………………  Level of drinking? .................................................  Alcohol Care Team (ACT) referral? .............................................  Recreational drugs? ………………………………………………………  Dependent drug user? …………………………………………………………..  Current or history of use of non-prescribed drugs / illicit drugs? ………………………………………………  Smoking? If yes, how much? ....................................................    If there is alcohol or substance misuse, does the patient have access to community services?  Yes    No  **Communicable diseases?**  HIV     Hepatitis B/C  **Flu/covid vaccination is available for all homeless patients**  Agrees   Declined  **CVD?**  Pulse rate (number in bpm) ……………………..  Regular or irregular Yes    No  Blood pressure (systolic and diastolic numbers in mmHg) …………………………… | |

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| 1. **Is the patient being admitted or being discharged**   Please follow the flow chart  Patient  Admitted  Discharged  Contact Housing SPOC or directly Ring Housing Officer – *Insert phone no.*  If you reach answerphone, please leave message stating patient’s name and location.  Does the patient want help in finding a safe place to go?  Yes  No  No further action to be taken  Please proceed to actions below  **In-Hours**  Add in local services here e.g. Hospital in-reach team.  **Out of hours please contact the:** Add in your local services here e.g. Emergency Duty Team on ‘*insert no*.’  Does the Patient have a Management plan or Keyworker  No  Yes  If yes, ensure management plan actioned/key worker details noted  If patient is not registered with a GP, give further advice/help to register and have agreement in place with local GP practice/ICS to send Discharge Summary. | | |
| Top tips - Against any option please check patient is registered with GP if not please link back to point 5 | | |
| Signature:  …………………………………………………………………….. | Print name: | |
| Designation: | Date: DD / MM / YYYY | Time: 00:00 |

**Duty to Refer: This form is the suggested detail required to complete the Duty to Refer.**

**Please maintain a copy within Patient Notes.**

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| **Duty to Refer Form: – Please complete basic information below:** | | |
| Date of hospital attendance: |  | |
| Persons name: |  | |
| Date of birth: |  | |
| Contact number: |  | |
| Contact email: |  | |
| Last settled address: |  | |
| Reason for referral: |  | |
| Any other comments: |  | |
| Dependants: Y N (if “yes” is ticked, please list details below) | | |
| Children (please list names and ages) | **Actions taken** | |
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| Pets | **Actions Taken** | |
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| Referral made by: | Print name: | Signature: |
| Designation: | Date:  DD / MM / YYYY | Time:  00:00 |

**Annex 1**

The below is the complete Duty to Refer form – it has been abbreviated above for ease of use within ED departments but is included here for reference.

Duty to Refer Form - [Homelessness: duty to refer - GOV.UK (www.gov.uk)](http://Homelessness:%20duty%20to%20refer%20-%20GOV.UK%20(www.gov.uk))

Duty to refer form should be completed and sent to relevant local authority homelessness team email which can be found here: <https://www.gov.uk/government/publications/homelessness-duty-to-refer/local-authority-duty-to-refer-emails>

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| **Please insert the name of the local housing authority that the service user is being referred to.** | | | | |  | |
| NOTE: Service users can choose which local housing authority they wish to be referred to. However, it is advisable for them to choose a local authority with which they have a local connection. In general, a service user is likely to have a local connection to an area if they live or have lived there, wok there or have a close family connection. However, a service user should not be referred to an area where they would be at risk of violence.  A guide to the duty to refer includes advice on the duty to refer and local connection. | | | | | | |
| **(1A) Written Consent to share information**  I agree to the information on this form being shared with \_\_\_\_\_\_ Council. I understand that the Council may use this information to contact me, and to help assess my needs for assistance with housing and that I am not making a homelessness application. I have read \_\_\_\_\_\_\_ privacy notice and understand how my data will be processed.  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NOTE: The service user must give consent to the referral. Referrers are advised to obtain signed consent to the referral; however, oral consent can be provided. The referrer must therefore complete box 1B. | | | | | | |
| **(1B) Oral Consent to share information**  Having discussed the accommodation status of \_\_\_\_\_\_\_\_\_ (*insert service user name)* the service user, I can confirm that they provided me with oral consent to refer their case to \_\_\_\_\_\_\_\_ Council. I explained to the Service User that the Council may use this information to contact them and to help assess their needs for assistance with housing and that this is not a homelessness application. | | | | | | |
| **Signed** | **Public authority** | | | | | **Date** |
| **Core information** Please note that sections 2 – 4 must be filled in. | | | | | | |
| **(2) About the referring professional (to be completed by the professional)** | | | | | | |
| Public authority referring (e.g. prison, hospital, etc.) | | | |  | | |
| Role of person referring (e.g. social worker) | | | |  | | |
| Name of referrer | | | |  | | |
| Address of referrer | | | |  | | |
| Email address of referrer | | | |  | | |
| Phone number of referrer | | | |  | | |
| Name and contact details of any other person who could be contacted for further information, if not the referrer (e.g. a support provider) | | | |  | | |
| **(3) Information and contact details for the service user being referred** | | | | | | |
| Name | | |  | | | |
| Household composition (e.g. single person, couple, family with X children/X adults) | | |  | | | |
| Current address (if applicable) | | |  | | | |
| Home telephone number | | |  | | | |
| Mobile number | | |  | | | |
| Email address | | |  | | | |
| Gender | | |  | | | |
| Date of birth | | |  | | | |
| Language and communication needs (identify any assistance the service user will need for an assessment to be completed) | | |  | | | |
| **(4) Main reason for referral** | | | | | | |
| What is the main reason you are referring the individual? | | | I believe they are homeless / I believe they are threatened with homelessness | | | |
| Please explain your answer (e.g. “they are facing eviction from their home”) | | |  | | | |
| **Additional information**  Please provide any additional information you are aware of which may help housing options officers support the individual. | | | | | | |
| **(5) Current accommodation** | | | | | | |
| What type of accommodation is the individual currently living in? | |  | | | | |
| If the service user is threatened with homelessness, on what date are they likely to become homeless? | |  | | | | |
| If the service user is due to leave prison or hospital, or is leaving the armed forces, with no accommodation available, please state when the release/ discharge will take place. | |  | | | | |
| **(6) Are there any additional needs/risks to be aware of?** | | | | | | |
| Additional needs/risks might include:   * previous history of sleeping rough * lack of support from family/friends * history of substance misuse * risk of domestic or other abuse | |  | | | | |
| **(7) Relevant medical information** | | | | | | |
| Please provide information on any physical or mental health needs that the service user has, and any treatment that they are receiving | | |  | | | |
| **(8) Other information** | | | | | | |
| Please provide any additional information. In particular, are there any known risks to staff visiting the service user at home or any other issues that we need to be aware of prior to initial contact? | | |  | | | |