**Referral form – Community Navigation Network Front Door (SPOA – Single Point Of Access)**

*N.B. Shoreditch Trust operates a* ***Front Door to the Community Navigation Network****. This is a front door providing access to the following community navigation services:*

* *WellFamily Plus – Family Action*
* *Social Prescribing – Family Action*
* *Engage Hackney - Riverside*
* *Wellbeing Network – Mind CHWF*
* *Community Connections – Shoreditch Trust*
* *Dementia navigators – Alzheimer’s Society*
* *City Connections – Age UK*

*In addition, we work with Hackney Citizens Advice Bureau and Age UK as welfare and advice partners. (See leaflet about this network - for residents and professionals)*

*This referral process* ***DOES NOT replace existing referral routes*** *to these specific services. If you currently work directly with one of these services please continue to do so.*

*If you have questions, please just get in touch. >* ***0203 55 99 234***[***connect@shoreditchtrust.org.uk***](mailto:connect@shoreditchtrust.org.uk) ***or*** [***referrals@shoreditchtrust.org.uk***](mailto:referrals@shoreditchtrust.org.uk)

*Please note* ***residents can self-refer*** *using the above contact numbers*

|  |  |
| --- | --- |
| *Date of referral:* |  |
| *Referrer details: (name, e-mail, organisation, contact number)* |  |
| *Is this an urgent referral?* | *Yes/ No*  *(We aim to make first contact within 3 working days, unless urgent.)* |

***Essential info*** *(this is the minimal information we need to be able to accept a referral)*

|  |  |  |  |
| --- | --- | --- | --- |
| First Name: |  | Last Name: |  |
| Date of Birth: |  | Contact Number(s): |  |
| Address: |  | E-mail (if available): |  |
| Postcode: |  |  |  |
| Has this person consented to this referral? *(please ensure you have consent before referring)* | | Yes/ No | |
| Reason for referral/ changes they wish to achieve: | |  | |
| GP Surgery: *(this information is used to be able to connect with relevant support)* | |  | |
| Are you aware of any **risks**, for example to visit this person at their home? | | Yes (please give details)/ No/ Unknown: | |
| If referring for Dementia support, does this person have a diagnosis of dementia? | | Yes/ No / Unknown (Please include Next of Kin contact details too) | |

***Additional info*** *(not essential but helpful if you can provide us with this):*

|  |
| --- |
| *for example: gender, ethnicity, other support in place; health conditions; access or language needs; any care package; lives alone; contact details for next of kin?* |

Complete and return this form to [referrals@shoreditchtrust.org.uk](mailto:referrals@shoreditchtrust.org.uk) or [*connect@shoreditchtrust.org.uk*](mailto:connect@shoreditchtrust.org.uk)

To discuss making a referral or to refer over the phone, please call us on: 0203 55 99 234 / 020 7033 8587 / 020 7033 8501

Shoreditch Trust, 12 Orsman Road, London, N1 5QJ

*We observe strict rules and regulations about handling people's data. You can find out more about this by visiting our website* [*Shoreditch Trust | Shoreditch Trust Privacy Policy*](https://www.shoreditchtrust.org.uk/privacy-policy/) *or contact us for more details.*