**INDIVIDUAL CASE REVIEW REFERRAL FORM (ADULTS)**

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| **Date of Referral:** |  | | | |
| **Name of Referrer and Agency:** |  | | | |
| **Name of Adult:** |  | | | |
| **Address:** |  | | | |
| **Date of Birth:** |  | **Date of Death/ Incident (if relevant):** | |  |
| **DECISION CHECKLIST PART A - ADULT AT RISK CRITERIA** | | | | |
| Does the person have care and support needs?  Is the person unable to protect themselves against abuse or neglect? | | | YES/NO  YES/NO | |
| **If you have answered NO to any of the above questions then this person is not an adult at risk and this referral cannot proceed any further.** | | | | |
| **DECISION CHECKLIST PART B - TYPE OF REVIEW** | | | | |
| Has the person died? YES/NO | | | | |
| If no, has the person sustained potentially life threatening injury, or; YES/NO  sustained serious and permanent impairment of health? YES/NO | | | | |
| Was Abuse or Neglect potentially associated with the event detailed above? YES/NO  Yes/No | | | | |
| Was Abuse or Neglect suspected prior to the event detailed above? YES/NO  Yes/No | | | | |
| Is there an indication that Abuse or Neglect was not recognised or shared with others? YES/NO | | | | |
| Is there an indication that Abuse or Neglect was not acted on appropriately? YES/NO | | | | |
| Has the Adult at Risk been a person in respect of whom a local authority has determined  to take action to protect from abuse or neglect in the last 6 months? YES/NO | | | | |
| Was the person abused in a regulated setting? YES/NO | | | | |
| Have you identified any learning relating to multiple organisations and/or is there a  potential to identify and improve multi-agency practice and partnership working YES/NO | | | | |
| Has this case been subject to an Adult Protection Investigation? YES/NO  If yes, what was the outcome? | | | | |
| **RATIONALE FOR REFERRING THIS CASE:** | | | | |
|  | | | | |
| **HAS ANY OTHER REVIEW BEEN REQUESTED OR UNDERTAKEN? Please provide details:** | | | | |
|  | | |  | |
| **BRIEF OVERVIEW OF AGENCY INVOLVEMENT** | | | | |
| **Adult Services:** | | | | |
| **CMHT:** | | | | |
| **Health:** | | | | |
| **Police:** | | | | |
| **National Probation Service:** | | | | |
| **Wales Community Rehabilitation Company:** | | | | |
| **Other:** please specify | | | | |
| **TO BE COMPLETED BY THE CHAIR OF THE CTMSB ADULT REVIEW GROUP:** | | | | |
| **DECISION OF THE ADULT REVIEW GROUP (including type of review or remit to Adults Quality Assurance Group):** | |  | | |
| **RATIONALE FOR DECISION:** | |  | | |
| **DATE:** | |  | | |

Please return to: Nicola Kingham, CTMSB Business Manager, Ty Catrin, Maritime Industrial Estate, Pontypridd, CF37 1NY or e-mail [nicola.j.kingham@rctcbc.gov.uk](mailto:nicola.j.kingham@rctcbc.gov.uk)