ULSTER GAA ADULT AT RISK REFERRAL FORM

**Please answer all relevant questions as fully as you can.**

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| **LOCATION**  |   |
| **NAME OF ADULT**  |   |
| **AGE/DATE OF BIRTH**  |   |
| **GENDER**  |   |
| **NAME OF CARER(S)** if known  |   |
| **HOME ADDRESS** if known  |   |
|   |
|   |

**PLEASE COMPLETE THOSE SECTIONS BELOW THAT ARE RELEVANT**

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| 1. **DISCLOSURE BY AN ADULT AT RISK**
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| **When was the disclosure made (dates and times)?**     |
| **Who did the adult make the disclosure to?**      |
| **What did the adult actually say?**              |
| 1. **INDICATORS**
 |
| **Describe any signs or indicators of abuse (with dates and times)**         |
| **Has the adult alleged that any particular person is the abuser?** **(If so please record details and the relationship, if any, to the adult below)**     |
| 1. **CONCERNS EXPRESSED BY ANOTHER PERSON ABOUT AN ADULT AT RISK**
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| **Record the concerns that were passed to you, with dates and times, and if possible ask the person who expressed the concerns to confirm that the details as written are correct.**         |
| 1. **DETAILS ABOUT ANY IMMEDIATE ACTION TAKEN, e.g. first aid**
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| 1. **CONCERNS EXPRESSED BY ANOTHER PERSON ABOUT AN ADULT AT RISK**
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| 1. **DOES THE ADULT HAVE ANY PARTICULAR NEEDS, e.g. communication, etc?**
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| **SIGNATURES**  |
| *To be signed by the person reporting the concern*  *Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Job Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  |
| *Date received and actioned by Adult Safeguarding Champion/appointed person*  *Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Action Taken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* *Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  |