**Vulnerable Adult Risk Management (VARM) Referral**

**Please complete all mandatory fields marked\***

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| **Referrer Details** |  |
| **Name of Referrer\*** |  |
| **Referrer Agency\*** |  |
| **Referrer Role\*** |  |
| **Referrer Telephone Number** |  |
| **Referrer Email Address\*** |  |

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| **Lead / Coordinating Agency Details (if known)** | |
| **Lead Agency** |  |
| **Lead Agency Contact Name** |  |
| **Lead Agency Address** |  |
| **Lead Agency Telephone No.** |  |
| **Lead Agency Email Address** |  |

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| **In the event that the social worker is unavailable for subsequent VARM meetings following the initial meeting, another agency will be appointed to chair the meeting. This is essential to ensure continuity and progress in supporting the vulnerable adult. By designating an alternative chairperson, the VARM meetings can proceed as planned, allowing the necessary discussions, decision-making, and coordination of actions. The chairperson will be responsible for minuting and sharing the minutes and actions agreed within the meeting.** |

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| **Alternative Chair Agency Details\*** |  |
| **Alternative Chair Agency** |  |
| **Alternative Chair Name** |  |
| **Lead Agency Telephone No.** |  |
| **Lead Agency Email Address** |  |

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| **Person at Risk Details** |  |
| **Mosaic ID** |  |
| **NHS Number** |  |
| **Name\*** |  |
| **Date of Birth\*** |  |
| **Age** |  |
| **Address\*** |  |
| **Telephone Number** |  |

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| **Person at Risk GP Details** |  |
| **GP Surgery** |  |
| **Address** |  |
| **Telephone Number** |  |

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| **Other people living at the address / sharing the accommodation (including children) \*** | |
| **Name** |  |
| **Date of Birth** |  |
| **Relationship to Person at Risk** |  |

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| **Does the person have the capacity to understand the identified risk and associated consequences? \*** |  |

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| 1. **What is the risk of serious harm or death? \*** | | | |
| Please tick all that apply |  |  |  |
| County Lines | Cuckooing | Domestic Abuse | Drugs / Alcohol |
| FGM | Financial Abuse | Forced Marriage | Hoarding |
| Homelessness | Honour Based Abuse | Mental Health | Radicalisation |
| Self-neglect | Sexual Exploitation | Other | Please specify: |

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| **Please describe the risk(s):** |  |

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| 1. **Is there significant risk of harm to others? \*** | | |
| Yes | No | Unknown |

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| **Please describe the risk(s) to others:** |  |

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| 1. **What other agencies are involved? \*** | | | |
| Please tick all that apply |  |  |  |
| Adult Social Care | Fire Service | Police | NWAS |
| Environmental Health / Housing | Community Resilience Team | Drug and Alcohol Service | Children’s Social Care |
| NHS | Domestic Abuse Services | Mental Health Services | Probation |
| GP | Faith Organisation | Other | Please specify: |

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| **Please provide contact details for all agencies involved:** |  |
| **Please provide further details of agency involvement** |  |

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| **What are the views of the person and what do they want?**  **Please also record here what attempts have been taken to involve the person in this process.** |
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| **Does the person want to attend the VARM meeting?** | | |
| Yes | No | Unknown |
| **If yes, how would they like to attend?** | | |
| Attend the meeting in person | Attend the meeting virtually | Attend the meeting with support from someone |
| **If no, would they like someone else to represent them at the meeting?** | | |
| Yes | No | Unknown |

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| **If the person wants support or representation at the meeting, do they have someone who can do this?** | | |
| Yes | No | Unknown |
| **If yes, please provide details:** |  |  |
| **Name** |  |  |
| **Relationship** |  |  |
| **Contact details** |  |  |

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| **Does the person want to submit their views in advance of the VARM Meeting?** | | |
| Yes | No | Unknown |
| **If yes, please tell us how they would like to do this?** | | |
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| **Agencies required at the VARM meeting:** | | | |
| Please tick all that apply |  |  |  |
| Adult Social Care | Fire Service | Police | NWAS |
| Environmental Health / Housing | Community Resilience Team | Drug and Alcohol Service | Children’s Social Care |
| NHS | Domestic Abuse Services | Mental Health Services | Probation |
| GP | Faith Organisation | Other | Please specify: |

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| --- | --- |
| **Please provide further information about required agencies (if applicable):** |  |

**Please send completed referral forms to:** [**DutyCDO@wigan.gov.uk**](mailto:DutyCDO@wigan.gov.uk)