|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Title** | Mr Mrs Miss Ms | | | **Other title** |  | |
| **Name** |  | | | | | |
| **Address** |  | | | **Phone** |  | |
| **Mobile** |  | |
| **Email** |  | |
| **Date of Birth** |  | | |  |  | |
| **Referrer** |  | | | | | |
| **Organisation** |  | | | **Position** |  | |
| **Address** |  | | | **Phone** |  | |
| **Mobile** |  | |
| **Email** |  | |
|  |  | |
| **People supporting you** | | **Name** | **Address** | | | **Phone/**  **Post Code** |
| **Emergency Contact** |  | |  | | |  |
|  |
| **Care-coordinator** |  | |  | | |  |
|  |
| **GP** |  | |  | | |  |
|  |
| **Psychiatrist** |  | |  | | |  |
|  |
| **Family or Friend\*** |  | |  | | |  |
|  |
| **Others** |  | |  | | |  |
|  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Marital Status** |  | | **Dependant Children** |  | **Do you have a WRAP?Y/N** |  |
| **Carer? Y/N** |  | **If Yes, who do you care for?** | |  | | |
| **Mental Health Diagnosis** |  | | **How was your diagnosis determined** |  | | |
| **Date Diagnosis** |  | | **Secondary Diagnosis** |  | | |

|  |  |
| --- | --- |
| There are services in the area that can offer support to your Carer/Carers. Please tick the box to enable us to pass on details of these carers’ services to the person(s) identified. All information passed on will be done so in line with our Confidentiality Policy and the Data Protection Act 1998 | |
| **Do you want your friend / family member / carer involved in your support? Yes**  **If Yes, how would you like that involvement to happen? This might include, for example, being at your support planning meeting or being copied into letters** | |
|  | |
| **Reasons for Referral**  Having seen the service information what would you like to achieve through attending this service | |
|  | |
| **What helps you improve or maintain good mental health?**  **What support helps?** | |
|  | |
| **Please give details of any personal, social and cultural issues that might affect your ability to attend the service? This might include for example how childcare, spiritual practices or work times may affect how you could access the service.** | |
|  | |
| **Do you have any physical health problems or individual requirements that it would be helpful for us to know about? e.g. (physical or sensory) and/or might affect your ability to attend the service. Yes**  **If yes, please give details below.** | |
|  | |
| **How would you prefer us to communicate with you?**  **Phone Letter Email Address** | |
| **Rethink Mental Illness work within the NHS Accessibility Standards. Do you feel you have any particular communication needs and how can we best support these? E.g. by providing larger print materials, easy text, signer or interrupter etc.** | |
| **Communication Need:**  **Communication support:** | |
| **Referrer** | **Applicant** |
| Date  Signature | Date  Signature |

|  |
| --- |
| **-REFERRAL INFORMATION**  Please tick the following boxes to ensure that you have enclosed all the necessary, current and relevant information. To enable us to process the application promptly, please ensure that all documentation included in support of this application is current and the most up to date available. Failure to provide this information will delay the application.  Risk Assessments Crisis Plan where applicable  CPA Care Plan  Rethink expects that by signing this form you are declaring that all relevant information has been included in the above statements and all relevant and current documentation is included in support of this application.  Information supplied in this document and associated documents will be treated in line with our Confidentiality Policy and the Data Protection Act 1998 and will remain in a safe and confidential place within the Service.  Should we need to seek further clarification or additional information to support your referral we will contact the referrer. |

|  |
| --- |
| In order to support you and others using services we need to know what happens at times when you may feel at risk from yourself or from the actions of others. Please tell us about particular times that you feel at risk currently or have felt at risk in the past. It may help to consider the following list. Please discuss with your referrer and tick next to the examples below to indicate which, if any, of the issues listed below are relevant to you. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please Note:** The following information and page 3) is **ONLY** required **for self referrals OR** if you have **NOT** provided an **ISSP Safety and Support Assessment** (Please contact RMI if you have a query about this) or **Risk, CPA and Crisis information (as Above)** | | | | | | |
| **Potential Risk** | **Applicant** | | | **Referrer** | | |
|  | **never** | **Some-**  **times** | **always** | **never** | **Some-**  **times** | **always** |
| Social Isolation Withdrawing from contacts that you usually enjoy due to a change in your mental health |  |  |  |  |  |  |
| Vulnerability/exploitation frome.g. emotional/financial/physical abuse/domestic abuse |  |  |  |  |  |  |
| Neglect e.g. diet, self-care, personal safety |  |  |  |  |  |  |
| Negative thoughts/actions to self e.g. thoughts/actions of harm to self suicidal thoughts/actions |  |  |  |  |  |  |
| Negative thoughts/actions to others e.g. harm to others – verbal/physical/sexual/damage to property |  |  |  |  |  |  |
| Drug Abuse |  |  |  |  |  |  |
| Alcohol abuse |  |  |  |  |  |  |
| Delusions, hallucinations, paranoid or unusual thoughts |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Please can you indicate which service you would like to attend. If you would like to attend more than one please tick all those which apply.** | | | | | | | |
| **UCR,**  **Newport Pagnell** |  | **West Bletchley,**  **Community Centre** |  | **Mathiesen Centre,**  **Bradville** |  | **Centrecom,**  **CMK** |  |

|  |
| --- |
| **Please give details of the nature and context of any risk issues indicated above and also list any positive risk taking** |
| Please continue on next page if necessary |

|  |  |
| --- | --- |
| **Please tell us about ways you have found useful in the past in managing any of the risks indicated above. Please also refer to the referral part of this form in considering positive risk taking that you may be thinking about as part of achieving your goals.** | |
| **Risk identified** | **Details of how we can support you to manage this** |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Rethink Mental Illness is committed to the implementation of its Equality & Diversity Policy in all aspects of its work. To ensure that we know how effectively we are reaching people, it would assist us if you could complete this monitoring form so that we can ensure that the population we serve is fairly represented within services and that no minority group is subject to discrimination.  Rethink also aims to provide all its clients with services that are culturally sensitive, and your name is requested on this form in order that we might meet any specific needs you may have arising from your background.  **However, there is no obligation to complete the form** **or any of its parts** - if there is any section you prefer not to answer, please leave it blank, and feel free to remain anonymous if you wish.  The information will be kept in a database in accordance with the provision of the Data Protection Act 1998 (which allows for sensitive personal data to be held where necessary to monitor Equal Opportunities Policy.) Access to information that identifies individuals will be strictly restricted. However, information may be passed to other agencies involved in your care in order that they might provide you with a culturally sensitive service unless you express that you do not wish this to happen. You have the right to check that the information held about you is correct. | | | | | | | | | | |
|  |  | | | Gender |  | Date of | |  | | |
| Name |  | | | M/F |  | Birth | |  | | |
| What is your cultural background? Please tick as appropriate. | | | | | | | | | | |
| **Asian or Asian British** | |  | **Mixed** | | | | | | |  |
| Bangladeshi | |  | Asian and White | | | | | | |  |
| Indian | |  | Black African and White | | | | | | |  |
| Pakistani | |  | Black Caribbean and White | | | | | | |  |
| **Other Asian, describe below** | |  | **Other mixed, describe below** | | | | | | |  |
|  | |  |  | | | | | | | |
| **Black or Black British** | |  | **White** | | | | | | |  |
| African | |  | British | | | | | | |  |
| Caribbean | |  | Irish | | | | | | |  |
| **Other Black, describe below** | |  | **Other white, describe below** | | | | | | |  |
|  | |  |  | | | | | | | |
| **Chinese** | |  | **Any other ethnic group, describe below** | | | | | | | |
|  | |  |  | | | | | | | |
| **What is your sexuality? Please tick as appropriate** | | | | | | | | | | |
| Bisexual | |  | Homosexual | | | | | | | |
| Heterosexual | |  | **Other, please state** | | | |  | | | |
| **Prefer not to say** | |  |  | | | |  | | | |
| **What is your religion? Please tick as appropriate** | | | | | | | | | | |
| Buddhist | |  | Muslim | | | | | |  | |
| Jewish | |  | Sikh | | | | | |  | |
| Hindu | |  | None | | | | | |  | |
| Christian | |  | **Other, please state** | | | |  | | | |
| **Prefer not to say** | |  |  | | | |
| **Do you consider you have a disability? Please tick if yes** | | | | | | | | | | |
| Mental Disability | |  | Physical Disability | | | | | | | |
|  | |  |  | | | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name | | |  | | | | | |
| Address | | |  | | | | | |
|  | | |  | | | | | |
| I understand that Rethink Mental Illness needs to process my personal data, including data concerning my health and welfare, to process my referral for Rethink Mental Illness services and to provide these services to me. | | | | | | | | |
| I understand that Rethink Mental Illness may be required to provide my personal data to the public body which commissions Rethink Mental Illness services. | | | | | | | | |
| I confirm staff have discussed with me the circumstances when and the reasons why they may have to disclose personal data without my consent. | | | | | | | | |
| I confirm staff have provided me with a copy of the ‘how we use your personal information’ leaflet. | | | | | | | | |
| By signing this form, I give consent for Rethink Mental Illness to use my personal data as explained in this form, and to share the following data with the following agencies or individuals: | | | | | | | | |
| Name | Agency / Relationship | | | Contact Number | Data to be shared | Detail of data to be shared | | Date & Signature of staff |
|  |  | | |  |  |  | |  |
|  |  | | |  |  |  | |  |
|  |  | | |  |  |  | |  |
|  |  | | |  |  |  | |  |
|  |  | | |  |  |  | |  |
| Sign: | |  | | | | Date: |  | |

**This form will be reviewed with you every six months; however, you have the right to amend this form at any time. If you wish, you can see a copy of the data which we hold on you by contacting Jon Macpherson at** Rethink Mental Illness, Community Support Services, Room 2, 11 Winchester Circle, Kingston, Milton Keynes, MK10 0B