

|  |
| --- |
| For Office Only |
| Staff Taking Referral: |
| Date: |
| RIS Number: |

SANCTUARY COMMUNITY MENTAL HEALTH SERVICE

*Please ensure that all boxes on this form are filled in, if not applicable please state this. Forms not completed with all the required information may be sent back.*

**Referring Organisation**

|  |  |
| --- | --- |
| Name of Referrer: | Address: |
| Organisation: | Postcode: |
| Position/Relationship: | Tel No: |

**Applicant Information**

|  |  |
| --- | --- |
| Name: | Date of Birth: |
| Address: | Male Female Transgender  Non – Binary Gender Fluid Other  *If other, please state:* |
| Tel No: | Mobile: |
| Email: | Other way to contact: |

**Signatures**

*Health Professionals ONLY Signature*

|  |  |  |
| --- | --- | --- |
| Signed: | Name: | Date: |

*Applicants Signature*

|  |  |  |
| --- | --- | --- |
| Signed: | Name: | Date: |

**Ethnicity**

|  |  |  |  |
| --- | --- | --- | --- |
| White British | White Irish | White Other | Black African |
| Black Caribbean | Black Other | Asian Indian | Asian Pakistani |
| Asian Bangladeshi | Asian Other | Chinese | Other: |

**Sexuality**

|  |  |  |  |
| --- | --- | --- | --- |
| Heterosexual | Homosexual | Bisexual | Pansexual |
| Asexual | Fluid | Prefer not to say | Other: |

**Religious Belief**

|  |  |  |  |
| --- | --- | --- | --- |
| Christianity | Buddhism | Judaism | Islam |
| Hinduism | Sikhism | Paganism | Spiritualism |
| Muslim | None | Prefer not to say | Other: |

**Marital Status**

|  |  |  |
| --- | --- | --- |
| Married | Single | Co-Habiting |
| Civil Partnership | Divorced | Widowed |
| Separated | Prefer not to say | Other: |

**Employment Status**

|  |  |  |
| --- | --- | --- |
| Employed | Unemployed | Retired |
| Volunteering | Student | Carer |
| Long-Term Sick | Prefer not to say | Other: |

**Dependant Children & Caring Responsibilities**

|  |
| --- |
| Number of Dependant Children: |

|  |
| --- |
| Do you have any Caring Responsibilities? If YES, please detail: |

**Mental Health Diagnosis**

|  |
| --- |
| Mental Health Diagnosis: Please give as much detail as possible: |

**Emergency Contact**

|  |  |
| --- | --- |
| Name: | Tel No: |
| Relationship: | Mobile: |

**Others Involved In Your Care**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Carer** | **GP** | **CPN** | **Consultant** | **Other** |
|  |  |  |  |  |
| Tel No: | Tel No: | Tel No: | Tel No: | Tel No: |

*Would you like a Carer involved in your support & Support Planning? YES NO*

**Reason For Referral**

|  |
| --- |
| Why do you want this Service? |

**Which part of the service would you like to access?**

*Please tick those you are interested in:*

Peer Support Groups Safe Space Volunteering Well Being Workshops Targeted Goal Focused One-One Support

**Health Problems**

|  |
| --- |
| Do you have any health problems we need to be aware of? YES NO |

*If YES please detail in the box below:*

|  |
| --- |
|  |

**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.* Please note that this form is compliant with the Data Protection Act 1998.

**Safety Management Plan**

**Confidential**

|  |  |
| --- | --- |
| Name: | Date Completed: |

**POTENTIAL RISK ISSUE APPLICANT REFERRER**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Never** | **Sometimes** | **Always** | **Never** | **Sometimes** | **Always** |
| **Social Isolation**  e.g., withdrawing from contact that you usually enjoy due to a change in your mental health |  |  |  |  |  |  |
| **Vulnerability/Exploitation From Others**  e.g., emotional/financial/physical abuse/domestic abuse |  |  |  |  |  |  |
| **Neglect**  e.g., Selfcare, hygiene and diet. |  |  |  |  |  |  |
| **Negative Thoughts/Actions to Self.**  e.g., thoughts/actions to harm self or suicidal thoughts |  |  |  |  |  |  |
| **Negative Thoughts/Actions to Others.**  e.g., harm to others – verbal/physical/sexual/damage to property |  |  |  |  |  |  |
| **Drug Abuse** |  |  |  |  |  |  |
| **Alcohol Abuse** |  |  |  |  |  |  |
| **Delusions, Hallucinations, Paranoia** |  |  |  |  |  |  |

**Risk Management Plan**

*Please tell us ways your risks have been or are being managed.*

|  |  |
| --- | --- |
| Risk Identified | How can we support you manage this? |
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|  |  |
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|  |  |

Name of person completing form in CAPITALS:

|  |
| --- |
|  |

Signature:

|  |
| --- |
|  |

Date:

|  |
| --- |
|  |

**Consent to Process and Disclose Data**

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |

**I understand that Rethink Mental Illness needs to process my personal data, including data concerning my mental 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.**

|  |
| --- |
| 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** |
|  | Rethink Mental Illness | 01922 494 479 | Anything to do with mental health, any risk issues. | Anything to do with mental health, any risk issues. |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Sign: |  | Date: |  |