**Referral Form**

Please complete the mandatory fields marked**\***

| **Date of Referral**: / /  |
| --- |
| **Nature of Referral**: Self-Referral ☐ Community Mental Health Team ☐ GP Referral ☐ Friend/Family member ☐ Hospital Referral ☐ Supported housing provider ☐ Other (please provide details): ☐  |
| **\*Referred by**: *(If self-referral, please leave blank)*   | **\*Position**:    |
| **\*Agency**:    | **\*Landline Number**:  |
| **\*Email**:  | **Mobile number**:  |
| **Fax Number**:  |   |
| **Beneficiary Details**  |
| **Title**:    | **\*Forename**:   | **\*Surname**:   |
| **\*Address**:  | **\*Phone Number/s**:  |
| **\*Postcode**:  | **\*D.O.B**:  | **\*First Language**:  |
| **\*N.I. Number**:  |
| \***Reason for referral**: *(please include current mental health status, relevant history and presenting needs)*        |
| **What are your support needs**: (*please tick areas where support is required)*  |
|  | Support to attend appointments  |  | Support with shopping  |  | Support to engage in community activities (e.g. Day Centre/Cinema/ Theatre/Outings etc.)  |  |
| Support with paperwork (e.g. correspondence, paying bills)  |  | Tenancy related support (applying for HB, paying rent and maintenance issues)  |  | Support around Meaningful Use of Time (e.g. Employment or Education.)  |  |
| Support with benefits  |  | Support Daily Living Skills (e.g. preparing and cooking a meal.)  |  | Support with house work (e.g. Cleaning and Laundry)  |  |

|   | Support around managing Medication (e.g. prompting/ reminding to order and collect medication.)  |   |   |   |   |   |
| --- | --- | --- | --- | --- | --- | --- |
|  |
| **Would you like the support to start on/by a specific date, please give date:**  |
| **\*Physical / health / special needs**:        |
| **\* Please describe any Current Home Treatment Team involvement and Anticipated Duration of Support at the moment:**  |
|           |
| **If yes, which team/who?:**  | **Named Worker:**  |
| **Current Medication:**  |
|            |
| **\*Mental Health Diagnosis & History**:  |
|           |

| **\*GP name**:  | **Contact no.**:  |  |
| --- | --- | --- |
| **\*Surgery address**:   |  |
| **\*Consultant name**:  | **\*Based at**:  |  |
| **\*Other agencies involved**:     |  |
|  | **\*Risk Assessment**:  |  |
| Risk Assessment  | Historical Risks  | Current risk  |  |
| ?  | Y  | N  | ?  | Actual  | High  | Med  | Low  |
| Suicidal acts / ideation/Intent  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  |
| Self-harm  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  |
| Violence / Aggression/ harm to others and Self  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  |
| Sexualised / sexually harmful behaviours  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  |
| Arson  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  |
| Eating disorder  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  |
| Substance misuse  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  |
| Neglect / poor self-care  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  |
| Vulnerability of Self/ to abuse / exploitation from Others.  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  |
| Lone Working Risk  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  |
| Other  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  | ☐  |
| Summary Current of risk factors *(e.g. what, when, where, why, how often, cause for concern regarding risk)?*  |  |
|     |  |
| Frequency of Support:  |  |
|

| Daily  |   |
| --- | --- |
| 4-5 Days per Week  |   |
| 1-3 Days per Week  |   |
| Estimated Weekly Supported Hours  |   |

 |  |
|  |  |
|  What other Information about you do you think we should know to help us support you?        |  |
|  |  |
|    |  |
| Main Carer / next of kin contact details:  |  |
| Name:  | Contact number/s:  |  |
| Address:    |  |
| Postcode:  | Relationship to client:  |  |
|   |  |
| Please list any children under 18 who currently live with you: None ☐  |  |
| Name  | Date of birth  | Name  | Date of birth  |
|  |  |  |  |
|  |  |  |  |
| Additional family/ relationships information:         |  |

|  | \*Equal Opportunities  |
| --- | --- |
| OpenMinds believes in actively promoting equality of opportunity. Please help us to monitor the effectiveness of our Equal Opportunities Policy, identify and challenge discrimination, and promote diversity by completing this form. Age: Gender: Male ☐ Female ☐ Prefer not to say ☐ other *(please state)* ☐ Ethnicity: Do you consider yourself to have a disability? Yes ☐ No ☐ Prefer not to say ☐ If you answered yes, which category best describe your disability? Mental ☐ Physical ☐ Sensory ☐ Learning Difficulties ☐ Other:  |

\*Disclosure

*We are required by the Data Protection Act 2003 to have the client’s consent for us to 1) request information from or share information with other services 2) keep a record of their support from OpenMinds. All information will be dealt with as per OpenMinds’ Data protection & Confidentiality Policy.*

Please Circle as required

| Is the Client aware of this referral and scope of the Service  | Yes  | No  |
| --- | --- | --- |
| Is the Care Coordinator aware of the referral  | Yes  | No  |
| Risk Assessment Supplied to OpenMinds  | Yes  | No  |
| Consent to Share information signed and sent to OpenMinds  | Yes  | No  |
|   Please tick the above boxes to confirm that you understand and gave consent  I confirm that the client has agreed to this information being passed to OpenMinds. The client understands that information may be passed to other agencies. Client’s name: Date:  |

| \*Additional paperwork required with referral  |
| --- |
| Full Risk Assessment and Care Plan    |

| \*Where this form should be sent  |
| --- |
| Electronic copies  | Paper copies  |
|  OpenMinds – info@openmindssocialcare.co.uk  |  OpenMinds Social Care Ltd Southbridge House, Southbridge Place Croydon, CR0 4HA   |

*If you have any queries, please call us on 02081439152 / 07704234055*

# Consent Form

| ***Please read this form carefully, complete the restriction section if appropriate and sign as indicated.*** I **agree** that the information provided may be shared with other health and social care agencies who can contribute to my care. I understand that: * This information will be used for the purpose of providing a service to me.
* Agencies may use anonymous information for statistical purposes and that the law may allow in some circumstances for other agencies to be provided with information about me.
* In exceptional circumstances, OpenMinds will share information about me to other agencies.
* I may withdraw my consent to share information at any time and this may result in a reduction of services that are available to me.
* I have the right to restrict what information may be shared and with whom, but this may affect the provision of care to me.
* My information will be held securely on paper on computer in accordance with the Data Protection Act 1998.

 I have made the following restrictions (if applicable):   Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Please note that you can alter your consent at any time.*  |
| --- |
|  I hereby give permission for OpenMinds Social Care Ltd to advocate on my behalf with the relevant agencies:     Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Please note that you can alter your consent at any time.*  |