Floating Support Referral Form

Please ensure the person being referred knows and agrees to the referral.

PLEASE COMPLETE THE MANDATORY FIELDS MARKED *

***Date of referral:** ……..

***Nature of referral**: Self-Referral ☐ Community Mental Health Team ☐ GP Referral ☐

Friend/Family member ☐ Supported Housing Provider ☐

Other (please provide details) ☐ ……..

Details of the person making the referral (if self-referral, please leave blank and move onto the next section):

***Name**: ..... ***Position**: .....

***Agency**: ..... ***Email:** .....

Telephone/Mobile: .....

Details for the proposed recipient of support:

Title: .....

***Forename**:..... ***Surname:**.....

***Address**: .....

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***Postcode**:.....

Telephone/mobile: ……

***D.O.B**:.....

***First Language:**..... ***NI number:**.....

Reason for the referral:

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Type of support needed (please tick all the relevant boxes):

☐ Emotional and mental health support (e.g. counselling)

☐ Short-term advocacy

☐ Support to attend appointments

☐ Support with grocery shopping

☐ Support to engage in community activities (e.g. day centre/cinema/theatre/outings etc.)

☐ Support with personal administration (e.g. correspondence, paying bills)

☐ Tenancy related support (applying for housing benefit, maintenance issues, paying rent/utilities)

☐ Support around meaningful use of time (e.g. employment, education)

☐ Support with Universal Credit

☐ Support with 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:.....

The frequency of the support required: Daily ☐ 4-5 days a week ☐ 1-3 days a week ☐

Other (please specify) ☐ …….....

Total estimated weekly support hours: ……..

Physical health / special needs:

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Please list any professionals who are currently involved in your care:
e.g. social worker / CPN / Counsellor / Health Visitor / Other: **1.** **2.** **3.** **4.** **5.**
Please describe any current Home Treatment Team involvement, and the anticipated duration of their support:

Which team:	**Named worker:**

Mental Health Diagnosis & History (please include the dates of any diagnosis, and ongoing illness):
1. **2.** **3.** **4.** **5.** **6.** **7.**
Current medication (please list what illness is being treated) and dosage:

Risk Assessment							
	Historical Risk			Current Risk			
	N/A	Yes	No	High	Medium	Low	No
Suicidal acts / ideation / intent	☐	☐	☐	☐	☐	☐	☐
Self-harm	☐	☐	☐	☐	☐	☐	☐
Violence / aggression / harm to others	☐	☐	☐	☐	☐	☐	☐
Sexualised / sexually harmful behaviours	☐	☐	☐	☐	☐	☐	☐
Arson	☐	☐	☐	☐	☐	☐	☐
Eating disorder	☐	☐	☐	☐	☐	☐	☐
Substance misuse	☐	☐	☐	☐	☐	☐	☐
Self-neglect / poor self-care	☐	☐	☐	☐	☐	☐	☐
Vulnerability to abuse / exploitation from others	☐	☐	☐	☐	☐	☐	☐
Lone working Risk	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

Summary of current risks factors (what/when/where/why/how often/cause for concern):

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Please note details on this page refer to the proposed recipient of support.

GP Details

***Surgery Name:**.....

***Surgery Address:** .....

..... **Postcode**:.....

***GP consultant name**:.....

***Telephone:** .....

Main carer / Next of Kin contact details:

***Relationship to person being referred:**..... .....

***Full Name:**.....

***Address:**.....

..... **Postcode**:.....

***Telephone**:.....

Caring for: please list any children under 18 who currently live with you:

Name: .....

Age: .....

Additional Family/relationships information: .....

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Disclosure

We are required by the Data Protection Act 2018 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.
If you are not the recipient of support, please confirm that the person you have referred is aware of this referral and consents to this information being shared with OpenMinds; and that the information may be passed onto other agencies (we will inform you in this event).

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 and on computer in accordance with the Data Protection Act 1998.

I have made the following restrictions (if applicable):

Signature: .....

Print Name:..... **Date:**.....

Please note that you can alter your consent at any time.