



# Activity to Work Group REFERRAL FORM



Employment



Support

Supporting people to increase their mental wellbeing through physical activity, social inclusion

This referral form can be completed by the referrer or the client. It is recommended that if this referral form is completed by the referrer that it is completed with the client present or at least with their given consent. As clients have access to their notes, please state if there is any reason why this referral form should not be shown to them.

## Terms and conditions:

- Clients must be aged over 18, have an understanding of their mental health and show a willingness to respect the confidentiality and dignity of all staff, volunteers and service users.
- The service must be informed should the client relapse to a level where they are unable to attend the service.
- The service reserves the right to refuse or discontinue a client's placement with the service if they are in breach of their agreement or if the service is deemed inappropriate to the client.

## REFERRER DETAILS

Surname:	First Name:
Agency:	Team:
Position:	
	Postcode:
Email address:	
Tel number(s):	
How are you involved in this persons' care?	

## YOUR/CLIENT DETAILS

Title: Mr/Mrs/Miss/Ms (delete as appropriate)		
Surname:	First name:	
Address:		
	Postcode:	
Tel number:	Mobile number:	
Email address:		
Preferred contact:		
Date of birth:	National insurance:	
Next of Kin/Person available in the event of an emergency:		
Name:	Relationship:	Contact:

## CLIENT DETAILS (cont)

What is your gender?  Male  Female  Transgender

What is your ethnic origin? (please tick)

- |  |   |  |
|--|---|--|
| <input type="radio"/> White British          | <input type="radio"/> White and Black Caribbean | <input type="radio"/> Other Asian Background |
| <input type="radio"/> White Irish            | <input type="radio"/> White and Black African   | <input type="radio"/> Indian                 |
| <input type="radio"/> Other White Background | <input type="radio"/> White and Asian           | <input type="radio"/> Pakistani              |
|  | <input type="radio"/> Other Mixed Background    | <input type="radio"/> Bangladeshi            |

- |  |  |
|--|--|
| <input type="radio"/> Black or Black British | <input type="radio"/> Chinese            |
| <input type="radio"/> Caribbean              | <input type="radio"/> Other ethnic group |
| <input type="radio"/> African                | Please specify: _____                    |
| <input type="radio"/> Other Black Background |  |

What is your religion?

- |                                    |   |
|------------------------------------|---|
| <input type="radio"/> Christianity | <input type="radio"/> Sikh                              |
| <input type="radio"/> Buddhist     | <input type="radio"/> No religion affiliation or belief |
| <input type="radio"/> Hindu        | <input type="radio"/> Prefer not to say                 |
| <input type="radio"/> Jewish       | <input type="radio"/> Other, please specify             |
| <input type="radio"/> Muslim       | _____   |

Please indicate your immigration status

- Refugee  Asylum Seeker  EA National  N/A

Do you consider yourself to be a disabled person?

- Yes  No

How would you describe your sexuality?

- Heterosexual (Straight)  Bisexual  Unsure  
 Homosexual (Gay, Lesbian)  Other

Please could you indicate your current employment status (please tick all that apply)?

- |   |  |
|---|--|
| <input type="radio"/> In education full time  | <input type="radio"/> In training                              |
| <input type="radio"/> In education part time  | <input type="radio"/> Not in education, training or employment |
| <input type="radio"/> In employment full time | <input type="radio"/> Volunteering                             |
| <input type="radio"/> In employment part time |  |

Are you a carer?

- Yes  No

### Consent for Communication

Once we have conducted an initial consultation would you like to receive text message or phone reminders for the activities you are interested in taking part in and future appointments?

- Yes  No

Would you like to receive information on other Mind in Croydon services?

- Yes  No

Please give a description and history of the your mental health

Are you on any prescribed medication? Please give details including side effects.

Is there a history of violent, aggressive or sexually inappropriate behaviour?  
Please give full detailed report

Are there any other risks we need to be aware of?

Yes

No

If yes please give details:

Do you know of any other factors that may affect your ability to access our services?  
(For example physical health, sight or mobility)

#### Additional Information

Please give details of any other useful information. If you have any additional reports or letters that you feel would help us please attach copies when you return this form.

I declare that the details I have given on this form are accurate to the best of my knowledge.  
This referral form needs to be signed by both parties.

**REFERRER** (if applicable)

**CLIENT**

Signed \_\_\_\_\_

Signed \_\_\_\_\_

Dated \_\_\_\_\_

Dated \_\_\_\_\_

Print \_\_\_\_\_

Print \_\_\_\_\_

RETURN THIS FORM TO: Orchard House, 15A Purley Road, South Croydon, CR2 6EZ