



## Employment and Social Inclusion Services

# REFERRAL FORM

Mind in Croydon Employment & Social Inclusion Services aim to support people with mental health problems to take part in mainstream social, leisure and vocational activities within the community, including helping people return to work.

This referral form should only be completed with the client's permission. As clients have access to their notes, please state if there is any reason why this referral form should not be shown to them.

**In order to avoid any delay in processing this referral, please ensure that all sections of the form are completed and the hand writing is legible. Please ensure you have attached an up to date copy of the client's risk assessment and care plan, or social report. NB: This should not be more than 6 months old.**

**Please note: this referral cannot be processed if there is not sufficient information given.**

The person being referred must satisfy the following criteria before accessing any of our services.

Please indicate that your client satisfies each of the criteria by placing a ✓ in the relevant boxes.

### CRITERIA

1. Experience of suffering from a mental health difficulty
2. Willing to access services of his/her own free will
3. Has shown a recent history of having co-operated with his/her health professional
4. Shows a willingness to respect the confidentiality and dignity of all staff, volunteers and service users

### TERMS AND CONDITIONS FOR CONTINUED ACCESS:

- a. The project staff must be kept informed of any changes that have been made to a clients care plan.
- b. The project staff must be informed should there be a significant change in the client's mental state and/or if the person relapses to a level where they are unable to attend the service.
- c. The project staff reserve the right to refuse access or withdraw the service(s) in the event of misconduct or unsatisfactory attendance.

### FOR OFFICE USE ONLY:

Accepted

Yes

No

Complete

Yes

No

Comments .....

Signature .....

Print Name .....

Date .....

### CLIENT DETAILS

Title: Mr/Mrs/Miss/MS (delete as appropriate)	Client Ref no:
Surname:	First Name(s):
Address:	
	Postcode:
Tel Number:	Mobile Number:
Preferred Contact:	
Date of birth:	National Insurance:
<b>Next of Kin/Person available in the event of an emergency:</b>	
Name:	Relationship:
Address:	
	Contact:

### REFERRER DETAILS

Surname:	First Name:		
Organisation:	Team:		
Profession:			
Care Manager <input type="checkbox"/>	Psychiatrist <input type="checkbox"/>	CPN <input type="checkbox"/>	OT <input type="checkbox"/>
Gen. Practitioner <input type="checkbox"/>	Social Worker <input type="checkbox"/>	Support Worker <input type="checkbox"/>	Care Coordinator <input type="checkbox"/>
Other <input type="checkbox"/>	Please specify _____		
Address:			
	Postcode:		
Tel Number(s):			
Email address:			
Are any other agencies involved in the client's care? YES <input type="checkbox"/> NO <input type="checkbox"/>			
(If yes please specify)			
Contact Name:	Contact No:		
Address:			
	Post Code:		

1. Please indicate by ticking the relevant box which service(s) you are making a referral:

Employment Support*	<input type="checkbox"/>	Boxercise	<input type="checkbox"/>	Soft Furnishings	<input type="checkbox"/>
Active Minds	<input type="checkbox"/>	1-2-1 Support	<input type="checkbox"/>	Allotment/Growing Minds	<input type="checkbox"/>
Gym	<input type="checkbox"/>	Buddying Service	<input type="checkbox"/>		

\*(please ensure you complete section 18)

2. Reason for Referral

Please give a short description of why this person has been referred

3. Has the person referred been made aware of the referral?  Yes  No

4. Please give a description and brief history, of the client's mental health problem and current practical and social functioning.

5. Is the client prescribed any medication?  
(Please give details, including side effects and any need for supervision)

6. Is the client on Care Programme Approach (CPA)?

<input type="checkbox"/> Yes (please attach)	<input type="checkbox"/> No
<input type="text"/> / <input type="text"/> / <input type="text"/> Date of last CPA Review	<input type="text"/> / <input type="text"/> / <input type="text"/> Date of next CPA Review

7. Does the client have a history of substance misuse?  yes  no

If yes, please give details:

8. Does the client have a recent history of violent, aggressive or sexually inappropriate behaviour?

Yes

No

If yes please give details and possible triggers:

9. Does the client have a recent history of non-compliance with medication?

Yes

No

If yes, please give details:

10. Does the client have a recent history of non-engagement with services?

Yes

No

If yes, please give details:

11. Are there any other risk factors that we need to be aware of?

Yes

No

If yes, please give details:

12. Do you know of any factors that may affect the client's ability to access our services?

Yes

No

(For example physical health, sight, mobility or literacy problems)

If yes, please give details:

13. What sort of support do you provide to the client?

14. Do you have any discharge plans?

Yes

No

If yes, please state how long the person is likely to remain under the care of the CMHT)

..... months

15. Is the client currently attending or been referred to any other organisation for support?

Yes

No

If yes, please give details including contact name and address:

16. Has the client been referred to this service before?

Yes

No

If yes, please state when:

Year ..... Month.....

### 17. 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.

### REFERRALS FOR EMPLOYMENT SUPPORT SERVICE ONLY

#### 18. Vocational needs assessment

Please advise on the client's readiness for work and if you believe they are able to make vocational decisions?

### DECLARATION

I declare that the details I have given on this form are accurate and to the best of my knowledge

I understand that as the referrer I will be the first point of contact in the event of a crisis or if the staff have any concerns regarding the welfare of the above named client. I will maintain contact with this person until responsibility is transferred to some one else, at which time I will inform the staff of Mind Employment & Social Inclusion Services.

Signed: ..... Print: ..... Date: .....

**\*\*PLEASE ENSURE A COPY OF THE CPA & RISK ASSESSMENT ARE ATTACHED TO THIS DOCUMENT\*\***

Thank you for taking the time to complete this form.

Please return your completed application to:

Mind Employment and Social Inclusion Services, Orchard House, 15a Purley Road,  
South Croydon, CR2 6EZ