Apr 2018

mind in Croydon
for better mental health

Employment Support

Employment Support Services

SECONDARY CARE REFERRAL FORM

Please only use this referral form if the client is accessing secondary care

Our service aims to support people with a mental health condition to take part in mainstream vocational activities within the community, including helping people return to work.

It is recommended that this referral form only be 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.

In order to avoid any delay in processing this application, please ensure that all sections of the form are completed in full and that the hand writing is legible. Please ensure you include a risk assessment and the current care plan along with a social report.

Terms and conditions:

a. The support worker must be kept informed of any changes that have been made to a clients care plan.

b. The support worker must be informed, should the client relapse to a level where they are unable to attend the service.

c. The Service Manager reserves the right to refuse or discontinue a client's placement with the service, if they are in breach of their agreement.

CRITERIA

- Adults aged 18 to 64 years. Service users younger than 18 years, or older than 64 years, may be accepted, if they are a client of the Croydon Integrated Adult Mental Health Service (IAMHS), directorate of the South London and the Maudsley NHS Foundation Trust (SLaM).
- Candidates must have an understanding of their mental health and be able to manage their medication, or have appropriate services involved if not taking medication.
- Candidates must be willing to access services of his/her own free will.
- Candidates must have shown a recent history of having co-operated with his/her health professional.
- Candidate shows a willingness to respect the confidentiality and dignity of all staff, volunteers and service users.

PLEASE COPY THIS PAGE FOR YOUR INFORMATION AND COMPLETE/RETURN THE REST OF THE FORM TOGETHER WITH THE RISK ASSESSMENT, SOCIAL REPORT AND CPA TO THE ABOVE ADDRESS.

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:	

REFERRER DETAILS

Surname:	First Name:
Agency:	Team:
Postion:	
Agency Address:	
	Postcode:
Tel Number(s):	
Are any other agencies involved in the client's care? Yes No	
(If yes please specify)	

Please give detailed explanation why you believe this person will benefit from accessing this service.

Client and referrer to identify clients need and desire for assistance in accessing: Vocational Opportunities, including work experience, further education, training and employment.

Please continue on a separate sheet if required.

Have you discussed this referral with the client? ☐ Yes ☐ No

If no please tell us why:

Please give detailed description and history, of the client's mental health condition and current practical and social functioning.

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

Is the client on a Care Programme Approach (CPA)?

☐ Yes (attach for all services) ☐ No

/ / Date of last CPA Review / / Date of next CPA Review

Is the client aware of his/her CPA plan and actions to be taken in event of a relapse? ☐ Yes ☐ No

Does the client have a history of violent, aggressive or sexually inappropriate behaviour?
Please give full detailed report

Are there any risks we need to be aware of? ☐ Yes ☐ No

If yes please give details:

Do you know of any factors that may affect the client's ability to access our services?
(For example physical health, sight, mobility or literacy problems)

What sort of support do you provide to the client and who will be the contact person?
Please give a named contact

Do you have any discharge plans? ☐ Yes ☐ No

If yes please state how long the person is likely to remain under CMHT ..... Months
Or attach a copy

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:

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.

CPA and Risk Assessment attached ☐ (please tick) Total number of additional pages ☐

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 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 in Croydon Employment Support Services.

REFERRER	CLIENT
Signed _____	Signed _____
Dated _____	Dated _____
Print _____	Print _____

Thank you for taking the time to complete this form.
Please return your completed application to address at the beginning of the form.

In accordance with Data Protection Law, we will only use your personal data for those purposes for which you have given your permission. A full copy of our Privacy Statement is available at www.mindincroydon.org.uk