

# Referral Form

**\* = mandatory**

<b>*Service/s Required</b> Housing Support <input type="checkbox"/> Floating Support <input type="checkbox"/> IRSS Community Support <input type="checkbox"/> Mums In Mind <input type="checkbox"/> Befriending <input type="checkbox"/> IRSS Accommodation <input type="checkbox"/> Smoking Reduction Service <input type="checkbox"/> St. Clair Gardens <input type="checkbox"/> Other?			*Date of Referral:
Title:	*Forename:	*Surname:	
*Address:		*Phone number/s:	
*Postcode:	*D.O.B:	*First language:	
*N.I. Number:		*Does the client have an appointee? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please give appointee details ( <i>name, contact details, relationship to the referred</i> ):			
Has the client used CW Mind services before? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, which service/s?			
*Referred by:		*Position:	
*Agency:		*Landline number:	
*Email:		Mobile number:	
<b>*Reason for referral:</b> ( <i>please include current mental health status, relevant history and presenting needs</i> )			
If you would like the support to start on/by a specific date, please give date ( <i>IRSS only</i> ):			
<b>*Physical / health / special needs:</b>			
*Has the client had involvement from mental health team/s (IPUs)? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, which one/s?		Named worker:	
<b>*Mental health history &amp; diagnosis</b> ( <i>please include date first diagnosed, diagnosed by (name &amp; position)</i> ):			
*GP name:		Contact no:	

*Surgery address:			
*Consultant name:	*Based at:		
*Other agencies involved:			
<b>Main carer / next of kin contact details:</b>			
Name:	Contact number/s:		
Address:			
Postcode:	Relationship to client:		
<b>If the person being referred is pregnant, what is their due date?</b> <span style="float: right;">Not applicable <input type="checkbox"/></span>			
Please list any children under 18 who currently live with the client: <span style="float: right;">None <input type="checkbox"/></span>			
<b>Name</b>	<b>Date of birth</b>	<b>Name</b>	<b>Date of birth</b>
<b>Additional family/ relationships information:</b>			

<b>*Equal opportunities</b>			
Coventry & Warwickshire Mind 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.			
<b>Age:</b>			
0-4 <input type="checkbox"/>	5-15 <input type="checkbox"/>	16-19 <input type="checkbox"/>	20-24 <input type="checkbox"/>
25-29 <input type="checkbox"/>	30-34 <input type="checkbox"/>	35-39 <input type="checkbox"/>	40-44 <input type="checkbox"/>
45-49 <input type="checkbox"/>	50-54 <input type="checkbox"/>	55-59 <input type="checkbox"/>	60-64 <input type="checkbox"/>
65-69 <input type="checkbox"/>	70-74 <input type="checkbox"/>	75-79 <input type="checkbox"/>	80-84 <input type="checkbox"/>
85+ <input type="checkbox"/>	Prefer not to say <input type="checkbox"/>		
<b>Gender:</b> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Other (please state) <input type="checkbox"/>			
Do you live and work in a gender other than that assigned at birth? Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to say <input type="checkbox"/>			
If you are female, are you pregnant, on maternity leave or returning from maternity leave? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>Marriage/civil part.:</b> Are you married or in a civil partnership? Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to say <input type="checkbox"/>			
<b>Sexual orientation:</b>			
Heterosexual <input type="checkbox"/>	Homosexual/Gay man <input type="checkbox"/>	Bisexual <input type="checkbox"/>	Lesbian/Gay woman <input type="checkbox"/>
Prefer not to say <input type="checkbox"/>	Other (please state) <input type="checkbox"/>		

**Disabilities:**

Do you consider yourself to have a disability? Yes  No  Prefer not to say

If you answered yes, which category does your disability best fit into?

Mental  Physical  Sensory  Learning Difficulties

**Religion:**

Christian (all denominations)  Buddhist  Hindu  Jewish  Muslim

Sikh  No religion  Pagan  Agnostic

Prefer not to say  Other (*please state*)

**Ethnicity:**

White: British  Irish  English  Scottish  Welsh  European

Other (*please state*)

Mixed: White / Black African  White / Black Caribbean  White / Asian

Other (*please state*)

Asian or Asian British: Indian  Pakistani  Bangladeshi

Other (*please state*)

Black or Black British: Caribbean  African

Other (*please state*)

Chinese or other ethnic group: Chinese  Other (*please state*)

**\*Risk Assessment****Key to Risk Assessment:**

**Actual:** known or disclosed occurrences or existence of risk

**High:** Disclosed intentions or frequent thoughts of risk

**Medium:** Risk present historically, but currently stable (no thoughts or intentions surrounding risk)

**Low:** No historical risk, no thoughts or intentions surrounding risk

**?** : Unknown

Risk Assessment	Historical Risks			Current risk ( <i>key above</i> )				
	?	Y	N	?	Actual	High	Med	Low
Suicidal acts / ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deliberate self-harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Violence / harm to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexualised / sexually harmful behaviours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neglect / poor self-care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vulnerability to abuse / exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Summary of risk factors** (e.g. what, when, where, why, how often, cause for concern regarding risk)?

### \*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 CW Mind. All information will be dealt with as per CW Mind's Data protection & Confidentiality Policy.

**I confirm that the client has agreed to this information being passed to CW Mind. The client understands that information may be passed to other agencies.**

Please check the box to consent to the above

**Client's name:**

**Date:**

Referrals are occasionally received which may be deemed appropriate for one or more of our services. Please check this box if the client agrees to this referral being transferred internally if appropriate (the client and referrer will be informed in this instance).

### \*Additional paperwork required with referral

Housing Support	Full Risk Assessment and Care Plan
Floating Support	Full Risk Assessment and Care Plan
I.R.S.S.	Full Risk Assessment and Care Plan
Mums in Mind	Full Risk Assessment
Befriending	Full Risk Assessment
St Clair Gardens	Full Risk Assessment, Care Plan and OT Assessment

### \*Where this form should be sent

Electronic copies	Paper copies
Housing Support – <a href="mailto:housingadmin@cwmind.org.uk">housingadmin@cwmind.org.uk</a>	Coventry & Warwickshire Mind Wellington Gardens Windsor St, Spon End Coventry CV1 3BT
Floating Support – <a href="mailto:floatingadmin@cwmind.org.uk">floatingadmin@cwmind.org.uk</a>	
I.R.S.S. – <a href="mailto:irss@cwmind.org.uk">irss@cwmind.org.uk</a>	
Mums in Mind – <a href="mailto:mim@cwmind.org.uk">mim@cwmind.org.uk</a>	
Befriending – <a href="mailto:mim@cwmind.org.uk">mim@cwmind.org.uk</a>	
Smoking Reduction – <a href="mailto:admin@cwmind.org.uk">admin@cwmind.org.uk</a>	
St Clair Gardens – <a href="mailto:irss@cwmind.org.uk">irss@cwmind.org.uk</a>	

If you have any queries, please call us on 024 7655 2847.