# Referral Form

Please ensure that all boxes on this form are filled in, if not applicable state this. Forms completed can be emailed to [derbyshirerecoverypeersupportservice@rethink.org](mailto:derbyshirerecoverypeersupportservice@rethink.org) or sent to ‘The Croft, Slack Lane, Ripley, Derbyshire, DE5 3HF. For further information please call us on 01773 734989.

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| --- | --- | --- | --- |
| **Date** |  | | |
| **Referrer** |  | | |
| **Organisation** |  | | |
| **Phone** |  | | |
| **Email** |  | | |
| **Self Referral?** |  | **Permission to make referral?** |  |

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| **Office use only** |
| **Person completing form:** |
| **RIS ID:** |
| **Service Area:** |
| **New to service?** |

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| **Applicant’s Details** | | | | | | |
| **Title** |  | | **Address** |  | | |
| **Full Name** |  | |
| **Date of Birth** |  | |
| **Email** |  | |
| **Contact Number** |  | | **Postcode** |  | | |
| **MH Diagnosis** |  | | |
| **Emergency Contact Details** | | | | | | |
| **Name** |  | **Relationship** |  | | **Contact no.** |  |

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| **Additional Information** | | | |
| **Communication needs**  **e.g. capacity/ability to read and understand information** |  | **Aspergers/Autism/ADHD** |  |
| **Visual/Hearing Impairments** |  | **Physical Disabilities** |  |
| **Learning Disabilities** |  | **Early onset dementia** |  |

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| **Are you currently receiving support from any other services?** | | | | | | | | |
| **Service** | **Contact Name / Address** | | | | **Contact Details** | | | |
| **GP** |  | | | |  | | | |
| **CMHT** |  | | | |  | | | |
| **Social Services** |  | | | |  | | | |
| **Other** |  | | | |  | | | |
| **Reason for referral - How can we support you?** | | | | | | | | |
| Targeted 1:1 Support | |  | Targeted Telephone Support | | |  | Access to peer support/groups |  |
| Please give an overview of reason for referral: | | | | | | | | |
| **Risks**  **Please outline any known risks including risks to self, others and substance misuse etc.** | | | | | | | | |
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| **Can you provide an up to date safety assessment (within the last 6 months)** | | | |  | | | | |

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| **Equal Opportunities Monitoring Questions** | | | | | | | | | | | | | | |
| **Gender** | | | | | | | | | | | | | | |
| Male |  | Female |  | Transgender |  | Non-binary |  | Gender Fluid |  | Other |  | Prefer not to say |  |

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| **Ethnicity** | | | |
| Please describe your ethnicity: | Prefer not to say |  |

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| **Religion** | | | | | | | | | | |
| Christianity |  | Buddhism |  | Judaism |  | Islam |  | Hinduism |  |
| Sikhism |  | Paganism |  | Spiritualism |  | Prefer not to say |  | None |  |
| **Other, please state:** | | | | | | | | | | |

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| **Sexuality** | | | | | | | | | |
| Heterosexual |  | Homosexual |  | Bisexual |  | Pansexual |  | Asexual |  |
| Prefer not to say |  | **Other, please state:** |  | | | | | | |

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| **Employment Status** | | | | | | | | | | |
| Employed |  | Unemployed |  | Retired |  | Volunteering |  | Student |  |
| Carer |  | Prefer not to say |  | **Other, please state:** | Long-term sick | | | | |

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| **How did you hear about this service?** | | | | | | |
| GP | CMHT | Facebook | Substance Misuse | Internet Search | Rethink | P3 |
| CAB | IAPT | Job Centre | Friend/Family/Carer | Adult Care | DFMH | Other |

By allowing the service to process this information you are accepting that we will hold the information on this form in line with Data Protection Policy and we may use it for monitoring purposes.