# 



**APPLICANT’S PREFERRED NAME AND CONTACT DETAILS:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Mr |  | Mrs | | |  | | Miss | |  | | Ms |  | | Other: | |  | | | | | |
| **Pronouns:** | | | | | | | | | | | | | | | | | | | | | |
| He  Him  His |  | | She  Her  hers | | |  | | They  Them  Theirs | |  | | Ze  Zir  Zirs | |  | Xe  Xem  Xirs | | |  | | Sie  Hir  Hirs |  |
| **Surname:** | | | | | |  | | | | | | | | | | | | | | | |
| **First Name(s):** | | | | | |  | | | | | | | | | | | | | | | |
| **Preferred Name:** | | | | | | | | | | | |  | | | | | | | | | |
| **Date of Birth:** | | | | | **Day** | | |  | | | **Month** | | |  | | | **Year** | |  | | |
| **Current Address:** | | | | | | | | | | | | | **Usual Address: (If different)** | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | | | | |
| **Postcode:** | | | |  | | | | | | | | | **Postcode:** | | | |  | | | | |
| **Home Landline Number:** | | | | | | | | |  | | | | | | | | | | | | |
| **Mobile Phone Number:** | | | | | | | | |  | | | | | | | | | | | | |
| **E-mail Address:** | | | | | | | | |  | | | | | | | | | | | | |

**EMERGENCY CONTACT:**

|  |  |  |
| --- | --- | --- |
| **Name:** |  | |
| **Relationship to you:** | |  |
| **Telephone number(s)** | |  |
| **Email Address:** | |  |

**GP NAME AND ADDRESS:**

|  |  |  |
| --- | --- | --- |
| **Name:** |  | |
| **Surgery Address:** | |  |

**ALTERNATIVE CONTACT:** **(friend / family / carer / or professional who will be involved in their support):**

**It is essential that we can communicate with clients to arrange meetings and discuss the support we can offer them. We understand that talking on the phone, texting, opening and/or reading letters may be something they find difficult. Is there another person we can contact if we are unable to get in contact with the client you are referring to us?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | | | **Relationship to you:** | |  | |
| **Telephone Number(s):** | | |  | | | | |
| **Address:** | |  | | | **Email Address:** | |  |
|  | | | | |  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do they want their friend / family / carer or profession to be involved in their support?** | **Yes** |  | **No** |  |
| If yes, how would they like that involvement to happen? This might include, for example being at initial assessment, or being copied into any letters. | | | | |
|  | | | | |

**Rethink Carer’s Service** Rethink also has a Carer’s Service that offers support to families and friends (their carer/carers) and there are other carers’ services available in Bristol. **Please tick the box** to enable us to pass on details of these carers’ services to the person(s) identified. All information passed on will be done in line with Rethink’s Confidentiality Policy and the General Data Protection Regulation 2018.

|  |  |
| --- | --- |
| **Yes, please pass on details of carer’s services to their carer(s)** |  |

Rethink Carer’s can only offer support to carers who are supporting someone with a mental health illness.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Their carer would like support from Rethink Carers** | **Yes** |  | **No** |  |

**DEPENDENT CHILDREN**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do they have any dependent\* children?** | **Yes** |  | **No** |  |

\* *A dependent child is any****person aged 0 to 15 in a household****(whether or not in a family) or a person aged 16 to 18 in full-time education and living in a family with his or her parent(s) or grandparent(s).*

**REFERRER’S NAME AND CONTACT DETAILS:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | | | **Organisation:** | |  | | |
| **Position:** | |  | | **Relationship to you:** | | |  | |
| **Telephone Number(s):** | | |  | | | | | |
| **Address:** | |  | | | **Email Address:** | | |  |
|  | | | | |  | | | |
|  | | | | |  | | | |

**REASON FOR REFERRAL**

**Briefly, let us know about your client’s mental health.**

**A formal or informal diagnosis helps as does any information about their day-to-day struggles, what they say is preventing them from moving forward in their recovery and what help they would like to receive from us.**

***Please note this section is mandatory***

**WHAT SUPPORT DOES THE CLIENT NEED FROM RETHINK?**

**Please tick the boxes which apply to the services they would like from Rethink.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Techniques to help with anxiety related situations. i.e. talking about anxiety provoking triggers & teaching breathing & distraction techniques, some mindfulness tools & coping skills.** |  | **Signpost to Rethink groups. Please include your client’s email address (above) to help our group co-ordinator keep your client up-to-date of groups and taster sessions** |  |
| **Graded exposure work to anxiety provoking triggers to help build independence & confidence getting out and about** |  | **Support to find social and leisure options** |  |
| **Looking at educational, voluntary and paid work options** |  | **Find a support group** |  |

**MISSED APPOINTMENT POLICY**

With high demands on services, it is important we can be proactive when offering support. If an individual misses two appointments a letter will be sent asking them to get in touch within 14 days. If they fail to get in touch, then we will assume the individual is doing well and they no longer requires our support.

**COMMUNICATING WITH YOUR CLIENT:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please indicate which way(s) your client/patient will prefer to be contacted by Rethink Mental Illness | | | | | |
| **Phone** |  | **Letter** |  | **Email** |  |

**Note:** We will try to communicate with your client by their preferred option whenever possible**.** However, to effectively organise appointments it would help to speak with them directly by phone. Once we have completed the referral assessment, we expect to work with your client face to face in the community. We do not work with clients in their own home.

**INTERPRETERS:**

*Rethink is committed to providing equal access to our services which means we use interpreters when necessary.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do they need an interpreter to use our services? | | **Yes** |  | **No** |  |
| If yes, please tell us their preferred language(s) |  | | | | |
| Depending on availability of interpreters, would you have a gender preference for any face-to-face appointments? If so, please specify. |  | | | | |

**TRANSLATIONS:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Would they like this form, our service literature or other written correspondence throughout their time with us translated into a different language? | | **Yes** |  | **No** |  |
| If yes, please tell us their preferred language(s) |  | | | | |

**RISK INFORMATION:**

Please outline any known risks we will need to know about in the space below and attach any supporting information or risk assessments available.

|  |  |
| --- | --- |
| **Is the client:** | **Please say more about this:** |
| **At risk to themselves?** |  |
| **A risk to others?** |  |
| **At risk of harm from others?** |  |

**REFERRAL CHECKLIST:**

Please enclose any relevant, current and up-to-date information/documentation you have in support of this application, as we don’t have access to NHS records. Tick the boxes that apply.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Risk Assessment** |  | **Crisis Plan where applicable** |  | **CPA Care Plan** |  |

**DECLARATION:**

*Rethink understands that by signing this form you are declaring that all relevant information has been included in the above statements and all relevant and current documentation is included in support of this application.*

*Information supplied in this document and associated documents will be treated in line with Rethink’s Confidentiality Policy and the General Data Protection Regulations 2018 and will remain in a safe and confidential place within the Service.*

*Should we need to seek further clarification or additional information to support your referral we will contact the referrer.*

**Applicant’s Signature:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** |  | **Date:** |  |
| **Print Name:** |  | | |

**Referrer’s Signature:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** |  | **Date:** |  |
| **Print Name:** |  | | |

**Please email completed referral form to** [**bristolservices@rethink.org**](mailto:bristolservices@rethink.org)

**PLEASE CONTINUE TO OUR EQUALITIES MONITORING FORM.**

**EQUALITIES MONITORING FORM**

Rethink Mental Illness is committed to helping all Communities in Bristol including Black and Minority Communities that have had difficulties accessing our services previously. Please help us by completing this monitoring form so that we can measure how well we are meeting the needs of everyone living in Bristol. We can then reach out to those people or parts of our community that are not currently accessing our service.

**However, there is no obligation to complete the form** **or any of its parts** - **if there is any section your client prefers not to answer, please add an X to the box next to ‘Prefer not to answer’.**

**All information provided will be held on an anonymous basis so that no personal information can identify anyone.**

**Thank you for your help and for providing the information to help Rethink Mental Illness.**

**TELL US ABOUT THEIR ETHNICITY**

**Choose one section from A – E then add an X to the appropriate box to indicate their ethnic background.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A) Asian or Asian British** | | **B) Black or Black British** | | | **C) Other Ethnic Groups** | | **D) Mixed / Multiple Ethnic Groups** | | **E) White** | |
| Bangladeshi |  | African | |  | Arab |  | White and  Asian |  | British |  |
| Chinese |  | Caribbean | |  | Iranian |  | White and Black African |  | Eastern European |  |
| Indian |  | Somali | |  | Iraqi |  | White and Black Caribbean |  | Gypsy |  |
| Pakistani |  | Nubian | |  | Kurdish |  | Any other mixed / multiple background.  Please state: | | Irish |  |
| Any other Asian background. Please state: | | Any other Black background.  Please state: | | | Turkish |  | Irish or Scottish Traveller |  |
| Any other ethnic background.  Please state: | | Roma |  |
| Any other White background Please state: | |
| Prefer not to answer: | | |  | | | | | | | |

**TELL US ABOUT THEIR SEXUAL ORIENTATION**

**Please add an X to the box which best describes their sexual orientation**

|  |  |  |  |
| --- | --- | --- | --- |
| Bisexual |  | Heterosexual / Straight |  |
| Gay |  | Unsure / Questioning |  |
| Lesbian |  | Other, please define: |  |
| Pansexual |  | Prefer not to answer |  |

**TELL US ABOUT THEIR RELIGION, SPIRITUALITY OR OTHER BELIEFS.**

**Please add an X to the box which best describes your religion or spirituality or tell us about their religion in “any other religion, spirituality or belief”.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Buddhist |  | Sikh |  | | Jewish |  |
| Christian |  | No Religion |  | |  | |
| Hindu |  | Any other religion, spirituality, or belief: Please define below: | | | | |
| Muslim |  | Prefer not to answer: | |  | | |

**TELL US ABOUT THEIR DISABILITY.**

**Please add an X next to their appropriate disability or disabilities.**

|  |  |
| --- | --- |
| Mental Disability |  |
| Physical Disability |  |
| Sensory Disability |  |
| Learning Disability |  |

**TELL US ABOUT THEIR VISION AND HEARING**

**Please add an X next to their answer.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do they have a visual impairment which can’t be corrected by glasses? | YES |  | NO |  |
| Are they able to read? | YES |  | NO |  |
| Do they need help to understand information which is given to them in printed format or explained to them verbally? | YES |  | NO |  |
| Do they have any problems with their hearing? | YES |  | NO |  |

**TELL US WHICH GENDER BEST DESCRIBES THEM.**

**Please add an X next to their answer.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Male |  | Female | |  | Intersex |  |
| Please state your preference: | | |  | | | |
| Prefer not to answer: | | |  | | | |

**TELL US ABOUT ANY DEPENDENCY ISSUES.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do they have a dependency on alcohol, drugs or another substance as well as mental health support needs? | | Yes |  | No |  |
| Prefer not to answer: |  | | | | |

**THANK YOU FOR COMPLETING THE EQUALITIES MONITORING FORM**

**WHAT WILL WE DO WITH THIS INFORMATION?**

**We use the information to measure how well we are meeting the needs of everyone living in Bristol and reach out to those people who are not currently accessing our service.** **The information will be kept in a database in accordance with the provision of the General Data Protection Regulations 2018 (which allows for sensitive personal data to be held where necessary to monitor our Equality and Diversity Policy). Access to information that identifies individuals will be strictly restricted.**