|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Referral** |  | | |
|  | | | |
| *CLIENT DETAILS* | | | |
| **Client Name** |  | | |
| **Current Address** | **Postcode** | | |
| **Date of Birth** |  | **Gender** |  |
| **Contact Numbers** | Home: Mobile:  Email: | | |
| **Ethnic Origin** |  | **Religion** |  |
| **Preferred Spoken Languages** |  | **Interpreter required?** |  |
| **Diagnosis** |  | | |
| **Medication** |  | | |
| **Is the person on a CPA?** |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referring Agent/ Individual** |  | **Relationship to client** |  |
| **Name** |  | | |
| **Address** |  | | |
| **Telephone Number** |  | | |
| **Referrers Signature** | Date: | | |

Does the client **AGREE** to the referral **Y / N?**

At times it may be necessary for Cornwall Community Services to work with other organisations, therefore we may be required to **share information**. Would you be willing for us to share information? **Y / N?**

I consent for Rethink Mental Illness to process my personal information under the provisions of the Data Protection Act.

Client Signature: .................................................................. Date: ...............................

|  |  |
| --- | --- |
| **GP Contact Details**  **(Name, address & telephone)** |  |

|  |  |  |
| --- | --- | --- |
| *ARE THERE ANY OTHER AGENCIES INVOLVED IN CLIENT CARE?* | | |
| Contact Name & Title (i.e. social worker / CPN) | Agency Name & Address | Contact Number |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| *BACKGROUND INFORMATION (Please state)* | |
| **Who to contact in case of an emergency** e.g. family, friend  (Please provide full name, address & telephone number) |  |
| **Background information of client**  (Please provide full details – e.g. first diagnosed, sections, etc.)  **Does the client have any communication / information needs relating to a disability or sensory loss?** | **Y / N** (If yes please give details) |
| **Current situation of client**  (Please provide full details – e.g. anxiety, depression, bereavement, self-care, diet, etc.) |  |
| **Please provide details of patterns of behaviour (triggers) or problem areas which have lead to past breakdowns**  (Details required to help prevent/minimise future crises) |  |
| **Is there anything we need to be aware of when lone working?**  (Please provide risk assessment no older than 6 months)  (Please state if any concern to self and/or others) |  |
| **Reason for Referral**  (1-2-1 / Group) |  |
| **Any other relevant information**  (e.g. financial, housing, immigration, etc.) |  |

**How did you hear about the Service?** (e.g. leaflet, professional, website, etc.)

.......................................................................................................................................

|  |
| --- |
| *Completed form to be returned to:* |
| Service Manager,  Rethink Mental Illness,  Cornwall Community Services,  Betty Fisher Centre,  Southern Way,  Wadebridge, PL27 7BX  01208 815676 marianna.curtis@rethink.org |

|  |  |
| --- | --- |
| *(For Office Use Only)* | |
| **Name of person taking referral:** |  |
| **Date:** |  |
| **Form completed by:** |  |

**Diversity Monitoring Form**

Rethink Mental Illness is committed to the implementation of its Equal Opportunities Policy in all aspects of its work. **It would assist us if you could complete this monitoring form** so that we can ensure that the population we serve is fairly represented within services and that no minority group is subject to discrimination.

Rethink Mental Illness also aims to provide all its clients with services that are culturally sensitive, and your name is requested on this form in order that we might meet any specific needs you may have arising from your background.

**However, there is no obligation to complete the form or any of its parts** – if there is any section you prefer not to answer, please leave it blank, and feel free to remain anonymous if you wish. This form will be separated from the rest of the referral, to maintain anonymity, when processed.

Please tick the box below that most accurately describes your **ethnic background**. If you do not feel any of the boxes are appropriate, please tick “Other” and describe in your own words:

White British Black/Black British Caribbean

White Irish Black/Black British African

Mixed White and Black Caribbean Any other black background

Mixed White and Black African European

Mixed White and Black Asian Chinese

Any other mixed background Other …………………………………..

Asian/Asian British Indian

Asian/Asian British Pakistani

Asian/Asian British Bangladeshi

Any other Asian background

Please tick the box below that most accurately describes your **religious background**. If you do not feel any of the boxes are appropriate, please tick “Other” and describe in your own words:

Buddhist Muslim

Christian Sikh

Hindu Lutheran

Atheist Pagan

Agnostic Other, describe below

…………………………………….

What is your **sexuality**?

Lesbian Homosexual

Heterosexual Other, describe below

……………………………………

**Employment status**: Employed

Not employed

Do you have a **physical disability**? If yes, please describe below

The information will be kept in a database in accordance with the provision of the Data Protection Act 1998 (which allows for sensitive personal data to be held where necessary to monitor Equal Opportunities Policy). Access to information that identifies individuals will be strictly restricted. However, information may be passed to other agencies involved in your care in order that they might provide you with a culturally sensitive service unless you express that you do not wish this to happen. You have the right to check that the information held about you is correct.

**Please take a moment to check that you have given us all the information that we need:**

**Signature of a relevant health professional such as GP/CPN/Social Worker in Section 2.**

**Complete risk assessment with signature in Section 4.**

**Signed Data Protection Act consent form in Section 6.**

**The person being referred understands and agrees to being referred to Rethink Cornwall Services.**

**Our service and how to contact us**

Rethink Mental Illness, the leading national mental health membership charity, works to help everyone affected by severe mental illness recover a better quality of life. Cornwall Community Services is based in Wadebridge, and works with individual people experiencing mental ill health enabling people to build structure into their week. Our workers achieve this by working within the ‘**Recovery Model**’ to create action plans and identify a persons’ aims and objectives, thus supporting that person to work towards fulfilling their goals.

As part of Rethink’s commitment to community support for people with mental illness, we run groups and one-to-one work in Cornwall, and have a resource centre based in Wadebridge.

**Working together to help everyone**

**affected by severe mental illness**

**recover a better quality of life**

Rethink Cornwall Services

The Betty Fisher Centre

Southern Way

Wadebridge

Cornwall PL27 7BX

Tel. 01208 815676

[marianna.curtis@rethink.org](mailto:marianna.curtis@rethink.org)

**For further information on Rethink Mental Illness**

**Phone 0300 5000 927**

**Email** [**info@rethink.org**](mailto:info@rethink.org)

[**www.rethink.org**](http://www.rethink.org)

Registered in England Number 1227970

Registered Charity Number 271028

Registered Officer 89 Albert Embankment London SE1 7TP

Rethink Mental Illness is the operating name of National Schizophrenia

Fellowship, a company limited by guarantee

Rethink Mental Illness 2011

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RMI_MasterLogo transp - EPS.epsOur timetable is reviewed on a continual basis, so please get in touch with us if you would like more details about what group activities we are offering. Suggestions for additions to our programme are always welcome. We can also provide directions to our groups and the Wadebridge Centre. We can be contacted at:



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