SOS REFERRAL FORM

Survivors of Suicide Service, Brighton & Hove

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|  REFERRAL FORM **Carer** □ **Self** □ **Agency** □  |
| Referring Agency: | Referrer’s Name: |
| Date referred: | Contact No: |
| Address: | Email: |
| Client’s Name: | Gender: |
| D.O.B: Age: | Contact No: |
| Address: | Email: |

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| **Has the client given permission for SOS to leave a message on his/her answer-phone?** Yes □ No □ Didn’t Ask □ **Please state other communication requirements;** |
| **Other Professional Involvement** (please circle)CMHT G.P CPN SW Care Co-ordinator Other (details): |
| Name of preferred Emergency contact. Also, add other professionals involved in this person’s support/care. Please mark C.P.A. Care Co-ordinator with an asterisk; add contact details of other professionals involved in the client’s care below |
| **Who to contact in case of Emergency** | Name; Relationship ie family, friend, other; | Tel:Email; |
| Psychiatrist |  | Tel: Email: |
| Social Worker  |  | Tel: Email: |
| Care Co-ordinator |  | Tel: Email: |
| GP |  | Tel: Email: |
| CMHT |  | Tel: Email: |
| CPN |  | Tel: Email: |

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| **Risk Assessment filled in?**  Yes □ No □  |
| Please confirm that the client has been consulted about this referral, and consents to referral Information being shared with the SOS service: Yes □ No □  |
| Client Signature: |
| Is this the client’s first suicide attempt? Yes □ No □  |
| Summary of current circumstances leading to this referral |
| Any other relevant information |

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| **Risk Indicators** |
| Please tick any risk indicator that apply (or has applied in the past). Give details in the space provided. If insufficient space, use “**Any other information"** box on following page. |
| **Harm/Abuse of Others** |
| No Indication Past or Current Risk at time of Referral |  |  |
| Thoughts of Harming Others |  |  |
| Extreme Verbal Abuse / Threats |  |  |
| Physical Assault |  |  |
| Sexual Assault |  |  |
| Neglect: Disabled or Older Adult |  |  |
| Neglect: other Dependent |  |  |
|  **Safeguarding Children** |  **YES** | **NO** |
| Does referral have children that live with them? |  |  |
| How many children live with them? |
| What are the ages of the children? |
| Are Children Services involved with the children?  |  |  |
| If **Yes:** how? |
| **Deliberate Self Harm** |
| No Indication Past or Current Risk at time of Referral |  |  |
| Thoughts urging to Self-mutilate |  |  |
| Threats to Self-Mutilate |  |  |
| Incidents of Self-Mutilation |  |  |
| Suicidal Thoughts/Ideas/Urges |  |  |
| Suicidal Threats |  |  |
| Attempted Suicide |  |  |
| **Non-Deliberate Self-Harm** |
| No Indication Past or Current Risk at time of Referral |  |  |
| Neglect of Diet |  |  |
| Neglect of Physical Health  |  |  |
| Neglect of Self Care |  |  |
| Neglect of Personal Safety |  |  |
| Domestic risk |  |  |
| Road Safety Risk |  |  |
| Financial Lack of Awareness |  |  |

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| **Harm, Abuse Caused By Others** |
| No Indication Past or Current Risk at time of Referral |  |  |
| Has Been Victim of Exploitation |  |  |
| Has been victim of Assault |  |  |
| Has been victim of Abuse |  |  |
| Social Isolation |  |  |
| **Clinical / Care Risks** |
| No Indication Past or Current Risk at time of Referral |  |  |
| Drug Abuse |  |  |
| Alcohol Abuse |  |  |
| Delusions |  |  |
| Hallucinations (Visual Auditory) |  |  |
| Paranoid Delusions |  |  |
| Extreme (Morbid) Jealousy |  |  |
| Medication Non-Compliance |  |  |
| Non-Compliance Therapies |  |  |
| Self-Disengagement From Care |  |  |
| **Other Risk Behaviours** |
| No Indication Past or Current Risk at time of Referral |  |  |
| Arson |  |  |
| Hostage Taking |  |  |
| **Please Provide Any Other Information on Risk in the Space Provided Below** |
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| Current warnings (evidence of on-going risks in last 28 days): |

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| Please confirm that: |  |
| The client has been consulted about this referral, and consents to referral Information being shared with the SOS service. |  |

Referred by: ………………………………………………………… Date: ……………………

Referred organization / team:………………………………………………………………………

**Equal Opportunities Monitoring**

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|  **Gender** (*Please tick as appropriate)* |

□Male □Female □Transgender □Prefer not to say

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|  **Ethnic Background** (*Please tick as appropriate)* |
| WHITE | British |  |
| Irish |  |
| Any other white background please specify: |
| MIXED/MULTIPLE ETHNICGROUPS | White and Black Caribbean |  |
| White and Black African |  |
| White and Asian |  |
| Any other mixed / multiple ethnic background please specify: |
| ASIAN or ASIAN BRITISH | Indian |  |
| Pakistani |  |
| Bangladeshi |  |
| Chinese |  |
| Any other Asian background please specify: |
| BLACK/AFRICAN/CARIBBEAN or BLACK BRITISH | Caribbean |  |
| African |  |
| Any other Black background please specify: |
| OTHER ETHNIC GROUP | Arab |  |
| Any other ethnic group please specify: |
| PREFER NOT TO SAY |

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|  **Sexual Orientation** (*Please tick as appropriate)* |
| Bisexual |  | Gay Woman/Lesbian |  | Other |  |
| Gay Man |  | Heterosexual/ Straight |  | Prefer not to say |  |

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|  **Faith** (*Please tick as appropriate)* |
| Atheism |  |
| Ba’hai |  |
| Buddhism |  |
| Christianity |  |
| Hinduism |  |
| Islam |  |
| Jainism |  |
| Judaism |  |
| Pagan |  |
| Sikh |  |
| Agnostic |  |
| Other (please State) |  |
| Other Philosophical belief (Please State) |  |
| Prefer not to say |  |

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|  **Disability & Mental Health** (*Please tick as appropriate)*  |
| Do you consider yourself to have; a sensory \_\_, learning Disability/difficulty\_\_\_ or physical disability\_\_, Long Standing Illness\_\_, Developmental Condition\_\_ |  |
| Do you consider yourself to have a disability related to your mental health? |  |
| Neither applicable to me |  |
| Prefer not to say |  |
| Other Please State |  |
| Are Your Day to Day activity limited because of a health problem, disability which has lasted, or is expected to last at least 12 months?Yes a Little \_\_Yes a LOT\_\_No (Do not answer the next Question)Prefer not to say\_\_ |  |

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| Are Your Day to Day activity limited because of a health problem, disability which has lasted, or is expected to last at least 12 months?Yes a Little \_\_Yes a LOT\_\_No (Do not answer the next Question)Prefer not to say\_\_ |  |

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| **Are you a Carer?** Refer to guidelines | Yes\_\_No\_\_Prefer not to say\_\_\_ |
| If Yes, do you care for a….? | Parent\_\_Child with Special Needs\_\_Other family member\_\_\_Partner/spouse\_\_\_Friend\_\_\_Other (Please give details)\_\_\_ |
| Are you:Currently in the Armed Forces?A veteran / ex services man or woman of the UK Armed Forces?A member of a service man’s Immediate family?A Reservist or in part time service (eg; Territorial service) |  Yes\_\_\_ No\_\_\_\_ Yes\_\_\_ No\_\_\_\_ Yes\_\_\_ No\_\_\_\_ Yes\_\_\_ No\_\_\_\_ |

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|  **Age Range** (*Please tick as appropriate)* |
|  18-25 □ 26-35 □ 36-45 □ 46-55 □ 56-65 □ 66+ □  |