**Rethink Mental Illness**

The Bridge

Christchurch Avenue

Harrow

HA3 5BD

Phone 0208 427 8528

Email: BridgeFloatingSupport@rethink.org

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| Applicant details | |
| Name of applicant: | DOB: |
| Address: | Email: |
| NINO: |
| Contact phone numbers:  Home:  Mobile:  Other: |  |

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| Referring person / agency | |
| Name: | Role: |
| Service Address: | Contact phone numbers:  Office:  Mobile: |

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| Referral criteria. Please tick all relevant boxes | | | |
| Mental Health diagnosis (mandatory) |  | Resident of LB of Harrow (mandatory) |  |
| Older Person (65+) |  | Housing related floating support |  |
| EMI / Dementia |  | Supported housing |  |
| Low / Medium MH needs |  | Drug and Alcohol misuse / dependency |  |

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| Existing support details – please identify what support is already in place | |
| GP: | Care coordinator: |
| Social worker: | Support worker: |
| Psychiatrist: | Other: |

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| Next of kin |  |

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| Support needs. Please tick all that apply | | | |
| Mental health |  | Physical health |  |
| Learning disability |  | Homelessness |  |
| Visual impairment |  | Offending history |  |
| Hearing impairment |  | Substance misuse |  |
| Victim of Domestic abuse |  | Hygiene / neglect |  |
| Interpreter? Identify language / dialect |  |  |  |

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| Reasons for referral. Please summarise the reasons for the referral and what the client would like support with. |
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| Risk | | | |
| Please provide information about potential risks in order for us to process the referral and ensure the safety of our staff and help us assess the level of support the client needs. Please attach any risk assessments to the referral. Please note in some cases we may not be able to conduct a home visit where there is a significant health and safety risk. | | | |
|  | Yes / No | Low/ Med/ High | Details |
| Self-harm | No |  |  |
| Suicidal thoughts or attempts | No |  |  |
| Isolation and self-neglect | No |  |  |
| Violent / self-destructive behaviour | No |  |  |
| Exploitation from others | No |  |  |
| Hoarding | No |  |  |
| Environmental hazards | No |  |  |
| Substance misuse | No |  |  |
| Sexual offending | No |  |  |

**Please note we require an up-to-date risk assessment from mental health services where possible for every referral.**

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| Client consent |
| I give consent for the information contained in this form to be shared with Rethink Mental Illness.  Client’s name:  Client’s signature: |

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| Supporting documents. Please identify and attach any relevant supporting documents, assessments or reports. | |
| Care plan |  |
| Risk assessment |  |
| OT assessment |  |
| Other |  |

**Please email your referral and supporting documents to: Bridgefloatingsupport@rethink.org**

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| **Equal opportunities monitoring. Please tick all relevant boxes.** | | | |
| **Ethnicity** | | | |
| White UK |  | Asian Indian |  |
| White Irish |  | Asian Pakistani |  |
| White Other |  | Asian Bangladeshi |  |
| Black Caribbean |  | Asian Chinese |  |
| Black African |  | Asian Other |  |
| Black Other |  | Other – please specify |  |
| **Religion** | | | |
| Buddhist |  | Hindu |  |
| Christian |  | Jain |  |
| Jewish |  | Sikh |  |
| Muslim |  | Other, please specify |  |
|  |  | No religion |  |
| **Sexual Orientation** | | | |
| Heterosexual |  | Bisexual |  |
| Gay |  | Transgender |  |
| Lesbian |  | Prefer not to say |  |