**Date of referral** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

121 Recovery Support Service

The service will provide:

* Regular (usually weekly or fortnightly) and structured 121 support sessions towards a recovery goal of their own choosing from a named Mental Health Recovery Worker
* The service will be person-centred and empowering and will be for no longer than 4-6 months depending on support needs of the referee.
* Once support is finished the referee can choose to engage with any of our groups and we will look to signpost them to other services in the community where relevant
* The referee needs to have a goal that they are able to commit to and are requesting support to action. They need to be willing to engage with the support and in actions towards completing these goals.

Eligibility Criteria:

1. 121 recovery support sessions **need to have a referral from a Community Mental Health team or Primary care mental health professional along with risk assessment if receiving support from CMHT**
2. The support is for adults over the age of 18 years who are resident in Borough of Harrow

Referrer’s name

Name: Contact:

Organisation:

Position / Relationship: Tel no:

Health related information

Primary Mental health diagnosis (please include dates):

Other mental health issues:

Other relevant health related information and/or access support needs **(please circle or underline):**

|  |  |
| --- | --- |
| Visual Impairment | **Yes No** |
| Able To Read | **Yes No** |
| Able to understand information provided/ mental capacity | **Yes No** |
| Hearing Impaired | **Yes No** |

If Yes, please state requirement where relevant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diversity monitoring

Marital Status: Religion & Belief:

Ethnicity: Sexual Orientation:

Gender: Do you have any caring responsibilities? YES / NO

No. of Dependent Children: If YES, please give details

Reason for referral

Please state the goal of the client you are referring

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Others involved in care and support if not already been named above

|  |  |  |
| --- | --- | --- |
|  | **Name** | **Contact details** |
| Bentley House - Care-Coordinator or Psychiatrist |  |  |
| GP |  |  |
| Family or Friend\* |  |  |
| Others  (please specify) |  |  |

How would you prefer us to communicate with you? (Please tick below)

Phone Letter Email

We will try to communicate with you by your preferred option but there may be times when we are unable to do so.

Referrer’s signature

Signed: Date:

Print Name:

|  |
| --- |
| Client consent |

|  |
| --- |
| I understand that Rethink Mental Illness needs to process my personal data, including data concerning my health and welfare, to process my referral for Rethink Mental Illness services and to provide these services to me. |

|  |
| --- |
| I understand that Rethink Mental Illness may be required to provide my personal data to the public body which commissions Rethink Mental Illness services. |

I consent to the above and for the information contained in this form to be shared with Rethink Mental Illness

Client’s name: Client’s signature:

Date: