# Recovery College Community Inclusion Service

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Description automatically generatedGraphical user interface

Description automatically generated with medium confidence

# Referral Form

Please ensure that all boxes on this form are filled in, if not applicable state this. Forms completed can be emailed to [rccis@rethink.org](mailto:rccis@rethink.org) or sent to Queensway Clinic  
226 Queensway   
Bletchley   
Milton Keynes

MK2 2TE

For further information please call us on 01908 725351

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| --- | --- | --- | --- |
| **Date** |  | | |
| **Referrer** |  | | |
| **Organisation** |  | | |
| **Phone** |  | | |
| **Email** |  | | |
| **Self-Referral?** |  | **Permission to make referral?** |  |

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| **Office use only** |
| **Person completing form:** |
| **RIS ID:** |
| **Service Area:** |
| **New to service?** |

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| **Applicant’s Details** | | | | | | |
| **Title** |  | | **Address** |  | | |
| **Full Name** |  | |
| **Date of Birth** |  | |
| **Email** |  | |
| **Contact Number** |  | | **Postcode** |  | | |
| **MH Diagnosis** |  | | |
| **Emergency Contact Details** | | | | | | |
| **Name** |  | **Relationship** |  | | **Contact no.** |  |

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| **Additional Information** | | | |
| **Communication needs**  **e.g., capacity/ability to read and understand information** |  | **Asperger’s/Autism/ADHD** |  |
| **Visual/Hearing Impairments** |  | **Physical Disabilities** |  |
| **Learning Disabilities** |  | **Early onset dementia** |  |

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| **Are you currently receiving support from any other services?** | | | | | | | | | |
| **Service** | | **Contact Name / Address** | | | | **Contact Details** | | | |
| **GP** | |  | | | |  | | | |
| **CMHT** | |  | | | |  | | | |
| **Social Services** | |  | | | |  | | | |
| **Other** | |  | | | |  | | | |
| **Reason for referral - How can we support you?** | | | | | | | | | |
| Structured with Targeted 1:1 Support | |  | PLEASE TICK ONE OF  THE SERVICES | | | x | Unstructured Access to peer support/groups |  |
| Please provide an overview for the referral & reasons for structured/unstructured needs | | | | | | | | | |
| **Risks**  **Please outline any known risks including risks to self, others and substance misuse etc.** | | | | | | | | | |
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| **Can you provide an up-to-date safety assessment (within the last 6 months)** | | | | |  | | | | |

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| **Equal Opportunities Monitoring Questions** | | | | | | | | | | | | | | |
| **Gender** | | | | | | | | | | | | | | |
| Male |  | Female |  | Transgender |  | Non-binary |  | Gender Fluid |  | Other |  | Prefer not to say |  |

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| **Ethnicity** | | | |
| Please describe your ethnicity: | Prefer not to say |  |

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| **Religion** | | | | | | | | | | |
| Christianity |  | Buddhism |  | Judaism |  | Islam |  | Hinduism |  |
| Sikhism |  | Paganism |  | Spiritualism |  | Prefer not to say |  | None |  |
| **Other, please state:** | | | | | | | | | | |

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| **Sexuality** | | | | | | | | | |
| Heterosexual |  | Homosexual |  | Bisexual |  | Pansexual |  | Asexual |  |
| Prefer not to say |  | **Other, please state:** |  | | | | | | |

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| **Employment Status** | | | | | | | | | | |
| Employed |  | Unemployed |  | Retired |  | Volunteering |  | Student |  |
| Carer |  | Prefer not to say |  | **Other, please state:** | Currently on sick leave | | | | |

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| **How did you hear about this service?** | | | | | | |
| GP | The Spa | Facebook | ARC | Internet Search | Rethink | P3 |
| CAB | IAPT | Job Centre | Friend/Family/Carer | Adult Care | Works for us | Other |

By allowing the service to process this information you are accepting that we will hold the information on this form in line with General Data Protection Regulations and we may use it for monitoring purposes.