# A red sign with white text AI-generated content may be incorrect.

**Referral Form**

The Derbyshire Recovery and Peer Support service is commissioned to deliver practical mental health support to adults living in Derbyshire with a mental health concern. Whilst this service does not cover Derby City, similar support provision can be accessed from Derby City Life Links, who do provide support in the city.

Referrals must be aged 18+ (or 17 and in transition from CAMHS), be living in Derbyshire (or accessing support from Derbyshire based services) and their primary support need must be their mental health.

Our service is for low to medium risk recovery support for people who are already on their recovery journey looking for help working towards their recovery goals.

We cannot accept anyone who are deemed high risk or in crisis.

**Upon referral acceptance, all referrals will be added to area specific wait lists for mental health recovery workers.   
During this time, monthly telephone support will be provided to support wellbeing.   
As per our policy, if we are unable to make contact after 3 attempts, we will close the referral and confirm by letter.   
A new referral can be made at any time.**

|  |  |
| --- | --- |
| **Office use only** | |
| **Staff completing form:** | **Referral ID:** |
| **Service Area:** | **Partner Service:** |

|  |  |
| --- | --- |
| **Office use only - support needs** | |
| **F2F:** | **Telephone:** |
| **Group support:** | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Applicant’s Details** | | | | | |
| **Title** |  | | **Contact number(s)** |  | |
| **Pro nouns** |  | |
| **Full Name** |  | | **Any holidays/ appointments coming up where we meet not be able to reach you?** |  | |
| **Email** |  | |
| **Address** including postcode |  | | **Accommodation status** (Independent/ living with family/ supported living etc) |  | |
| **Address Type**  (Private/ Business/ care home) |  | |
| **Emergency Contact Details** | | | | | |
| **Name** |  | **Relationship** |  | **Contact no.** |  |

|  |  |  |
| --- | --- | --- |
| **Are you currently receiving support from any other services?** | | |
| **Service** | **Contact Details** | **Details of Support Given** |
| **GP** |  |  |
| **CMHT** |  |  |
| **Other** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Demographics** | | | |
| **Date of Birth** |  | **Marital Status** |  |
| **Ethnicity** |  | **Gender** |  |
| **Sexual Orientation** |  | **Gender same as birth** |  |
| **Religion** |  | **Employment Status (Full/ part time/ unemployed etc)** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **How can we support you?**  Please tick the box which is most applicable. However, we do encourage face to face support as we are a community based service. | | | | | |
| **Targeted 1:1 support** |  | **Telephone Support** |  | **Support to access and attend peer support groups** |  |
| Targeted 1:1 support is face to face and goal led, each goal is 6-8 weeks (there is room to extend depending on the service users development with the goal, this can be discussed with your allocated recovery worker). The service is about building individuals independence within the community. | | The telephone support is available to those who are unable to attend face to face support for a variety of reasons (e.g., due to their mental health condition; lack of transport; childcare or other caring responsibilities) and will be expected to receive a similar level of support to that delivered within communities (where appropriate). | | We support a wide range of peer support groups across Derbyshire, where those who have lived experience of mental illness can meet to gain mutual support and shared understanding. If you are interested in accessing these groups, you can do so independently without the need for a referral. If you need support to access a group, you can do this through targeted 1:1 support and a referral will be required. | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Client needs/ reasonable adjustments** | | | |
| **Neurodivergent (For Example, Autism, ADHD etc.)** |  | **Currently pregnant or have been in the last 12 months** |  |
| **Caring Responsibilities** |  | **Parental Responsibility** |  |
| **Able to read** |  | **Able to use the internet** |  |
| **Learning disability** |  | **Sensory disability** |  |
| **Preferred language** (Please state if translator is required) |  | **Physical Disability** |  |
| **Visual impairments** |  | **Hearing impairments** |  |
| **Speech impairment** |  | **Drug/alcohol dependency or misuse** |  |
| **Any other** |  | | |

|  |  |
| --- | --- |
| **Diagnosis and Health conditions** | |
| **Mental Health Diagnosis** (Include dates if possible and if these are primary or secondary conditions) |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referral Details** | | | |
| **Date referral made** |  | | |
| **Self-referral or referrer name** |  | | |
| **Organisation** (If external) |  | | |
| **Contact information** (If external) |  | | |
| **Permission to make referral** (if external) |  | | |
| **What is the reason for this referral?**  Please provide as much information as possible and give an overview of your/referee’s current situation, support in place, and what your/their goals for support are.  Try think about the following when setting your goals, are the goals achievable, are the goals practical, are you ready to start your goals, what will life feel like after I have achieved my goal. | | | |
|  | | | |
| **Risks**  Please outline any known risks to self or others including any forensic history including dates | |  | |
| **Can you provide an up-to-date safety assessment (within the last 6 months)?** If yes, please email this along with the form | |  | |
| **What are your hobbies and interests?**  Please list any hobbies you may have or any topics that are of interest. | | | |
|  | | | |
| **How did you hear about this service?** | | | **Have you accessed this service before?** |
|  | | |  |

Please ensure that **all boxes** on this form are filled in, if not applicable, please state this. Incomplete forms will be returned to the referrer. Forms completed can be emailed to [derbyshirerecoverypeersupportservice@rethink.org](mailto:derbyshirerecoverypeersupportservice@rethink.org) or sent to ‘The Croft, Slack Lane, Ripley, Derbyshire, DE5 3HF. For further information or support please call us on 01773 734989.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Full Name | | |  | | | | | | | |
|  | | |  | | | | | | | |
|  | | |  | | | | | | | |
| 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 commissioners of the service. | | | | | | | | | |  |
|  | | | | | | | | | | |
| I confirm staff have discussed with me the circumstances when and the reasons why they may have to disclose personal data without my consent. | | | | | | | | | |  |
|  | | | | | | | | | | |
| I confirm staff have provided me with a copy of the ‘how we use your personal data’ leaflet | | | | | | | | | |  |
|  | | | | | | | | | | |
| I am happy for Rethink Mental Illness to use my personal data, including data concerning my health, to undertake evaluation and research to help plan and improve services. | | | | | | | | | |  |
|  | | | | | | | | | | |
| By completing this form, I give consent for Rethink Mental Illness to use my personal data as explained in this form, and to share the following data with the following agencies or individuals: | | | | | | | | | |  |
|  | | | | | | | | | | |
| **Name** | | **Agency/ Relationship** | | **Contact number** | **Data to be shared** | | | **Detail of data to be shared** | **Date and signature of staff** | |
|  | |  | |  |  | | |  |  | |
|  | |  | |  |  | | |  |  | |
|  | |  | |  |  | | |  |  | |
|  | |  | |  |  | | |  |  | |
|  | |  | |  |  | | |  |  | |
| **This form will be reviewed with you when you are allocated a mental health recovery worker; however, you have the right to amend this form at any time. If you wish, you can see a copy of your data or how we use your personal data please contact us on 01773 734989.** | | | | | | | | | | |
| Sign | Click or tap here to enter text. | | | | | Date | Click or tap here to enter text. | | | |

The Derbyshire recovery and peer support service are the lead providers in delivering this service.  
Rethink Mental Illness (Chesterfield, Amber Valley, North East Derbyshire and Bolsover) work in partnership with Derbyshire MIND (Erewash), P3 (South Derbyshire) and The Derbyshire Federation for mental health (Derbyshire Dales and High Peak.)   
Information may be shared within this partnership where relevant to your support.

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