# 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.

Please ensure that **all boxes** on this form are filled in, if not applicable, please state this. 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.

**Incomplete forms will be returned to referrer**

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

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| **Office use only - support needs** | |
| 1:1 | **telephone** |
| **groups** | **combination** |

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| **Applicant’s Details** | | | | | |
| **Title** |  | | **Contact number(s)** |  | |
| **Pro nouns** |  | |
| **Full Name** |  | |
| **Email** |  | |
| **Address including postcode** |  | | **Are you currently residing at this address? (Staying with friends/family)** |  | |
| **Do you have no fixed abode?** |  | |
| **Best day/time to contact?** |  | | **Any holidays/ appointments coming up where we may not be able to contact you?** |  | |
| **Emergency Contact Details** | | | | | |
| **Name** |  | **Relationship** |  | **Contact no.** |  |

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

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| **Demographics** | | | |
| **Date of Birth** |  | **Marital Status** |  |
| **Ethnicity** |  | **Gender** |  |
| **Sexual Orientation** |  | **Gender same as birth** |  |
| **Religion** |  | **Preferred method of contact (Phone, email, text, face to face)** |  |

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| **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 (you can do this by phoning us on the above number) or if you need support to access a group, you can do this through targeted 1:1 support. | |

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| **Client needs/ reasonable adjustments** | | | |
| **Neurodivergent (For Example, Autism, ADHD etc.)** |  | **Currently pregnant or have been in the last 12 months** |  |
| **Able to read** |  | **Able to use the internet** |  |
| **Employment Status** |  | **Physical disability** |  |
| **Learning disability** |  | **Sensory disability** |  |
| **Preferred language** |  | **Requires translator** |  |
| **Visual impairments** |  | **Hearing impairments** |  |
| **Any other support needs or comments** |  | | |

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| **Diagnosis and Health conditions** | |
| **Mental Health Diagnosis (Include dates if possible)** |  |

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| **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. | | |
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| **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. | | |
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| **How did you hear about this service?** |
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| **Have you accessed this service before?** |
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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.