#



**APPLICANT’S PREFERRED NAME AND CONTACT DETAILS:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Mr |  | Mrs |  | Miss |  | Ms |  | Other:  |  |
| **Pronouns:** |
| HeHimHis |  | SheHerhers |  | TheyThemTheirs |  | ZeZirZie /Zirs |  | XeXemXirs |  | SieHirHirs |  |
| **Surname:** |  |
| **First Name(s):**  |  |
| **Date of Birth:** | **Day** |  | **Month** |  | **Year** |  |
| **Current Address:** | **Usual Address: (If different)** |
|  |  |
|  |  |
|  |  |
| **Postcode:** |  | **Postcode:** |  |
| **Home Landline Number:** |  |
| **Mobile Phone Number:** |  |
| **E-mail Address:** |  |

**EMERGENCY CONTACT:**

|  |  |
| --- | --- |
| **Name:** |  |
| **Relationship to you:**  |  |
| **Telephone number(s)** |  |
| **Email Address:** |  |

**GP NAME AND ADDRESS:**

|  |  |
| --- | --- |
| **Name:** |  |
| **Surgery Address:** |  |

**ALTERNATIVE CONTACT: (friend / family / carer / or professional who will be involved in your support):**

**It is essential that we can communicate with you to arrange meetings and discuss the support we can offer you. We understand that talking on the phone, texting, opening and/or reading letters may be something you find difficult. Is there another person we can contact if we are unable to get in contact with you?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Relationship to you:** |  |
| **Telephone Number(s):** |  |
| **Address:** |  | **Email Address:** |  |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you want your friend / family / carer or professional to be involved in your support?** | **Yes** |  | **No** |  |
| If yes, how would you like that involvement to happen? This might include, for example being at initial assessment, or being copied into any letters. |
|  |

**Rethink Carer’s Service** Rethink also has a Carer’s Service that offers support to families and friends (your carer/carers) and there are other carers’ services available in Bristol. **Please tick the box** to enable us to pass on details of these carers’ services to the person(s) identified. All information passed on will be done in line with Rethink’s Confidentiality Policy and the General Data Protection Regulation 2018.

|  |  |
| --- | --- |
| **Yes, please pass on details of carer’s services to my carer(s)** |  |

Rethink Carer’s can only offer support to carers who are supporting someone with a mental health illness.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **My carer would like support from Rethink Carers** | **Yes** |  | **No** |  |

**DEPENDENT CHILDREN**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you have any dependent\* children?** | **Yes** |  | **No** |  |

\* *A dependent child is any****person aged 0 to 15 in a household****(whether or not in a family) or a person aged 16 to 18 in full-time education and living in a family with his or her parent(s) or grandparent(s).*

**REASON FOR REFERRAL**

**Briefly, let us know about your mental health and how it impacts on your day-to-day life. A formal or informal diagnosis of a condition can be helpful. Is very useful to know what is preventing you doing what you normally do, and your current needs.**

*Please note this section is mandatory.*

**Please add a cross to the boxes which apply to the services you need from Rethink.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Techniques to help with anxiety related situations. i.e. talking about anxiety provoking triggers & teaching breathing & distraction techniques, some mindfulness tools & coping skills.**  |  | **Signpost to Rethink groups. Please include your client’s email address (above) to help our group co-ordinator keep your client up-to-date of groups and taster sessions** |  |
| **Graded exposure work to anxiety provoking triggers to help build independence & confidence getting out and about**  |  | **Support to find social and leisure options** |  |
| **Looking at educational, voluntary and paid work options** |  | **Find a support group** |  |

**MISSED APPOINTMENT POLICY**

Please note that if two appointments are missed you will be sent a letter giving you 14 days to get in touch. If you do not get in touch, we will assume that things are going well, and you no longer require support.

**COMMUNICATING WITH YOU:**

|  |
| --- |
| Please indicate which way(s) you would prefer to be contacted by Rethink Mental Illness |
| **Phone** |  | **Letter** |  | **Email** |  |

**Note:** We will try to communicate with you by your preferred choice whenever possible**.** However, to effectively organise appointments it would help to speak with you directly by phone. This will also help you get the best out of your placement with us.

**INTERPRETERS:**

*Rethink is committed to providing equal access to our services which means we use interpreters when necessary.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you need an interpreter to use our services?  | **Yes** |  | **No** |  |
| If yes, please tell us your preferred language(s) |  |
| Depending on availability of interpreters, would you have a gender preference for any face-to-face appointments? If so, please specify. |  |

**TRANSLATIONS:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Would you like this form, our service literature or other written correspondence throughout your time with us translated into a different language?  | **Yes** |  | **No** |  |
| If yes, please tell us your preferred language(s) |  |

**RISK INFORMATION:**

Please let us know any risks we need to know about when you have a mental health crisis.

|  |  |
| --- | --- |
| **Are you?** | **Tell us more about this:** |
| **A risk to yourself** (e.g., do you physically harm or neglect yourself, or binge eat)**?** |  |
| **A risk to others** (e.g., do you become physically or emotionally abusive)**?** |  |
| **At risk of harm from others** (e.g., you receive physical or emotional abuse, or pressure to pay for things)**?** |  |

**DECLARATION**

*Rethink understands that by signing this form you are declaring that all relevant information has been included in the above statements.*

*Information supplied in this document will be treated in line with Rethink’s Confidentiality Policy and the General Data Protection Regulations 2018 and will remain in a safe and confidential place within the Service.*

**Applicant’s Signature:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** |  | **Date:** |  |
| **Print Name:** |  |

**Please email completed referral form to** **bristolservices@rethink.org**

**PLEASE CONTINUE TO OUR EQUALITIES MONITORING FORM.**

**EQUALITIES MONITORING FORM**

Rethink Mental Illness is committed to helping all Communities in Bristol including Black and Minority Communities that have had difficulties accessing our services previously. Please help us by completing this monitoring form so that we can measure how well we are meeting the needs of everyone living in Bristol. We can then reach out to those people or parts of our community that are not currently accessing our service.

**However, there is no obligation to complete the form** **or any of its parts** - **if there is any section you prefer not to answer, please add an X to the box next to ‘Prefer not to answer’.**

**All information provided will be held on an anonymous basis so that no personal information can identify anyone.**

**Thank you for your help and for providing the information to help Rethink.**

**TELL US ABOUT YOUR ETHNICITY**

**Choose one section from A – E then add an X to the appropriate box to indicate your ethnic background.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **A) Asian or Asian British** | **B) Black or Black British** | **C) Other Ethnic Groups** | **D) Mixed / Multiple Ethnic Groups** | **E) White** |
| Bangladeshi |  | African |  | Arab |  | White andAsian  |  | British |  |
| Chinese |  | Caribbean  |  | Iranian  |  | White and Black African |  | Eastern European  |  |
| Indian |  | Somali  |  | Iraqi  |  | White and Black Caribbean  |  | Gypsy |  |
| Pakistani  |  | Nubian |  | Kurdish |  | Any other mixed / multiple background. Please state:  | Irish  |  |
| Any other Asian background. Please state: | Any other Black background.Please state: | Turkish  |   | Irish or Scottish Traveller  |  |
| Any other ethnic background.Please state: | Roma  |  |
| Any other White background Please state: |
| Prefer not to answer:  |  |

**TELL US ABOUT YOUR SEXUAL ORIENTATION**

**Please add an X to the box which best describes your sexual orientation**

|  |  |  |  |
| --- | --- | --- | --- |
| Bisexual |  | Heterosexual / Straight |  |
| Gay |  | Unsure / Questioning |  |
| Lesbian |  | Other, please define: |  |
| Pansexual |  | Prefer not to answer |  |

**TELL US ABOUT YOUR RELIGION, SPIRITUALITY OR OTHER BELIEFS.**

**Please add an X to the box which best describes your religion or spirituality or tell us about your religion in “any other religion, spirituality or belief”.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Buddhist |  | Sikh |  | Jewish |  |
| Christian |  | No Religion |  |  |
| Hindu |  | Any other religion, spirituality, or belief. Please define below: |
| Muslim |  | Prefer not to answer: |  |

**TELL US ABOUT YOUR DISABILITY.**

**Please add an X next to your appropriate disability or disabilities.**

|  |  |
| --- | --- |
| Mental Disability |  |
| Physical Disability |  |
| Sensory Disability |  |
| Learning Disability |  |

**TELL US ABOUT YOUR VISION AND HEARING**

**Please add an X next to your answer.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you have a visual impairment which can’t be corrected by glasses? | YES |  | NO |  |
| Are you able to read? I am diagnosed with Dyslexia | YES |  | NO |  |
| Do you need help to understand information which is given to you in printed format or explained to you verbally? | YES |  | NO |  |
| Do you have any problems with your hearing? | YES |  | NO |  |

**TELL US WHICH GENDER BEST DESCRIBES YOU.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Male |  | Female |  | Intersex |  |
| Please state your preference: |  |
| Prefer not to answer: |  |

**TELL US ABOUT ANY DEPENDENCY ISSUES.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you have a dependency on alcohol, drugs or another substance as well as mental health support needs? | Yes |  | No |  |
| Prefer not to answer: |  |

**THANK YOU FOR COMPLETING THE EQUALITIES MONITORING FORM**

**WHAT WILL WE DO WITH THIS INFORMATION?**

**We use the information to measure how well we are meeting the needs of everyone living in Bristol and reach out to those people who are not currently accessing our service.** **The information will be kept in a database in accordance with the provision of the General Data Protection Regulations 2018 (which allows for sensitive personal data to be held where necessary to monitor our Equality and Diversity Policy). Access to information that identifies individuals will be strictly restricted.**