Buckinghamshire Mind Referral Form

Please send to: FAO Office Administrator, Bucks Mind 260 Desborough Road, High Wycombe, Buckinghamshire HP11 2QR

or email [befriending@bucksmind.org.uk](mailto:befriending@bucksmind.org.uk) (01494 463 364)

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| --- | --- |
| **Referral Details** |  |
| **Name** (person being referred): |  |
| **Address:**  **Post code:** |  |
| **Contact Number(s)**: |  |
| **Email Address:** |  |
| **Date of Birth:** |  |
| **Referrer Name and Job Title:** |  |
| **How did you hear about us?** | **(Please select one)**     1. **GP** 2. **Social Care** 3. **Community Mental Health Teams** 4. **Promotional Event (please specify)** 5. **Family/Friend** 6. **Other (please specify)** |
| **Referrer Organisation:** |  |
| **Address:**  **Post code:** |  |
| **Contact Number(s):** |  |
| **Email Address:** |  |
| **GP Name:**  **Address:** |  |
| **Emergency Contact details:** |  |
| **Reason for Referral:** |  |
| **Client would benefit from:** | 1:1 In person volunteer support/befriending for 6 months (please be aware there may be a wait) o  Phone befriending o  Staffed wellbeing groups (there is a cost) o  Peer support in groups o |
| **HOME VISITS** |  |
| **Does the person require home visits?** | Y/N |
| **If yes- do you**  **visit the home safely?** | Y/N |
| **Is there any specific risk to a home visit?** | Y/N If yes-please specify |
| **Home situation including who lives there and any housing issues** |  |
| **Support required (by befriender and others):** |  |
| **Reason for home visit (physical or mental health)** |  |
| **Is getting out of the house a realistic goal?** | Y/N |
| **Client is aware of referral, is happy for us to make contact and to keep the information on this form for our records** | **o (Please tick box)**    Any other information? |
| **Date:** |  |

**We have a responsibility to keep our befriending and peer support volunteers safe and by sharing as much information as possible, this will help us to do this.**

**Please now complete the risk assessment:**

|  |  |
| --- | --- |
| **Support Plan and Risk Assessment**  **(to be completed by referrer as far as possible)** | |
| **Clients Name:** | |
| **Completed by:** | **Date:** |
| ***About current support received from referrer or other services:***  **Current interventions and service provision:**  **Frequency of contact:**    **By whom, where, when (include contact details):** | |
| **Is there any risk to Bucks Mind workers or volunteers when supporting this person?**  **If YES please give brief details:** | |
| **Is there any history of physical health problems which we should know about to work safely with this person e.g. falls, epilepsy etc?**  **If YES please give brief details:** | |
| **Is there any history of mental health problems which we should know about to work appropriately with this person?**  **If YES please give brief details:** | |
| **Is there any history of drug and alcohol problems we should be aware of?**  **If YES please give brief details:** | |
| **Relapse Indicators/Early Warning Signs (if known):** | |
| **Contingency (to prevent a crisis)/Crisis (when a crisis has occurred) Plan :** | |

Thank you for your referral. While we endeavour to make befriending partnerships for everyone **a referral is not a guarantee of a befriending partnership.**

We may also need to contact you further to proceed with the matching process if we need more information.