

**Office use only**:

|  |  |
| --- | --- |
| Talking Therapies |  |
| Secondary |  |

Name of staff:

**REFERRAL FORM**

**BEFORE COMPLETING THIS FORM, PLEASE ENSURE THAT THE**

**PERSON WHO IS BEING REFERRED HAS AGREED TO THE REFERRAL**

**AND HAS SIGNED TO SHOW THEIR CONSENT**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of referral** |  | | | | |
| **Client’s name** |  | | | | |
| **Date of birth** |  | | **Gender** | **Male**  **Female** | |
| **NHS number** |  | | | | |
| **Current address** |  | | | | |
| **Which area do you normally live?** *Please tick* | **Manchester**    **Other**  **Please state** | | | | |
| **Contact numbers** | **Home: Mobile:** | | | | |
| **Email address** |  | | | | |
| **Ethnic Origin** |  | **First or preferred language** | | |  |
| **Is an interpreter required?**  **If yes, please give details** | **Yes**   **No** | | | | |
| **Priority** | **Urgent**  **Routine** | | | | |
| **Preferred form of contact** | **Letter**  **Phone**   **In person**  **Email** | | | | |
| **Likely problems with contact:** *(difficult partner, intrusive relative, time of day)* | **Yes**   **No**  *If yes, please explain:* | | | | |
| **Preferred venue for the first contact** | **Home  GP practice**  **ACMHS**  **Other**   **Please state** | | | | |
| **Preferred worker** | **Male**  **Female**  **No preference** | | | | |

|  |  |
| --- | --- |
| **GP details** |  |
| **Name** |  |
| **Practice address** |  |
| **Telephone number** |  |
| **Referring agent/ individual** |  |
| **Name** |  |
| **Address** |  |
| **Telephone number** |  |
| **Relationship to client** |  |
| **Is anyone else involved in client’s care** | **Yes**  **No**  If yes, please state below |
| **Name** |  |
| **Address** |  |
| **Telephone number** |  |

**Has this person/self been referred to the service before? Yes**  **No**  **Don’t know**

**Are you a Refugee/Asylum seeker? Yes**  **No**

|  |  |
| --- | --- |
| **Does person/self AGREE to referral** | **Yes**  **No** |
| **Does person AGREE/self to assessment** | **Yes**  **No** |
| **Is the person/self on a CPA**  **Yes**  **No** | **Standard  Enhanced** |

**At times it may be necessary for ACMHS to work with other organisation’s, therefore we may be required to share information. Would you be willing for ACMHS to share information?** Yes  No

|  |  |
| --- | --- |
| **Would you like to receive information about ACMHS’ activities? Yes**  **No** | If yes, in what format would you like to receive information?  Email  Letter  Standard text  Whatsapp  Facebook  Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Reason for referral:** *Please tick all that apply*

|  |
| --- |
| Homelessness  Social/domestic problems  Employment  Benefits  Accommodation  History of mental health problems  Abuse: physical/sexual/verbal  Counselling  Other  *Please state:* |

**History of mental health problems:** *(eg: previous service involvement, recurrent depressive disorder, anxiety disorders, phobic anxiety and duration etc)*

|  |
| --- |
| **Diagnosis** (if applicable):  **Current mental state:** |

**Current medication:** *(include date first prescribed, compliance and side effects)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of medication** | **What is it being used to treat** | **Date first prescribed** | **Compliance**  **Yes / No** | **Any side effects, please state** |
|  |  |  |  |  |

**RISK FACTORS**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Current: Threats and violence |  |  |
| Current: Self harm |  |  |
| Current: Harm to others/staff |  |  |
| Current: Alcohol/drug abuse |  |  |
| Current: Self neglect |  |  |
| Any history of violent threats to others: (*If yes, please state)* |  |  |
| Any safeguarding concerns with children: (*If yes, please state)* |  |  |
| Are there any known environmental risks in relation to visiting the home? (*If yes, please state)* |  |  |
| Do you have any pets ie: dogs, cats, other pets/animals, that may pose a risk if the worker was to visit you at home?(*If yes, please state)* |  |  |

**REMINDER**

**Acute risk should be directed to the appropriate crisis service**

**ANY OTHER RELEVANT INFORMATION** eg: personal circumstances / statement from client

***ie:*** *Household (children in the house/childcare responsibilities, pregnant), Circumstances (financial, social etc), Personal history (relationships etc), Involvement with child services*,

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| --- |
|  |

|  |  |
| --- | --- |
| **Client’s signature:** |  |
| **Name (please print):** |  |
| **Signature of referrer:** |  |
| **Name (please print):** |  |
| **Date:** |  |

***Safeguarding statement:*** *ACMHS is committed to safeguarding and promoting the welfare of young people and vulnerable adults and expects all staff and volunteers to share this commitment.*

*Service users are encouraged to speak to an ACMHS staff member if they have any safeguarding issues.*

**SAFEGUARDING ADULTS AND CHILDREN’S STATEMENT**

* Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It's fundamental to high-quality health and social care.
* All our service users have the right to be treated with dignity and respect.
* We take a zero-tolerance approach to abuse and will not allow poor practice to take place. If someone is not being treated with dignity and respect, or there is a suspicion that this is the case, our staff will report it immediately and we will deal with it at once.
* We will take all Safeguarding issues seriously regardless of age, disability, gender reassignment, marriage and civil partner status, pregnancy and maternity, race, religion and belief, sex and sexual orientation.
* We will ensure that the six key principles of safeguarding inform our approach; Empowerment, Prevention, Proportionality, Protection, Partnership, Accountability.
* We will always act in the person’s best interest, taking a personalised approach and ensure their immediate wellbeing and safety.
* We will comply with national good practice, multi-agency protocols and legislative requirements including the Care Act 2014 statutory guidance.
* We will also work closely with Local Authority and Local Safeguarding Adults Boards (SABs) and Manchester Safeguarding Board.
* We will take all steps to protect and maintain the confidentiality of those involved and will only share information with required parties.

***Comments or complaints:*** *Comments or complaints you make will be given serious consideration and the appropriate action taken. This will help us to improve the quality, performance and delivery of our service.*

**Your rights**

As a data subject you have a number of rights: You can:

* Access and obtain a copy of your data on request
* Require us to change incorrect or incomplete data
* Require us to delete or stop processing your data, for example where the data is no longer necessary for the purposes of processing
* Object to the processing of your data where we are relying on our legitimate interests as the legal ground for processing
* Ask us to stop processing data for a period if data is inaccurate or there is a dispute about whether or not your interest override our legitimate grounds for processing data

If you would like to exercise any of these rights, or to make a subject access request, please contact [admin@acmhs-blackmentalhealth.org.uk](mailto:admin@acmhs-blackmentalhealth.org.uk)

If you believe we have not complied with your data protection rights, you can complain to the Information Commissioner: [www.ico.org.uk/global/privacy-notice/](http://www.ico.org.uk/global/privacy-notice/)

The NHS will use your personal information for research and planning without your consent, unless you opt out. Here is the information you need to opt out: [www.nhs.uk/your-nhs-data-matters](http://www.nhs.uk/your-nhs-data-matters) or call 0300 3035678

**Please return to the Administrator at:**

*African and Caribbean Mental Health Services*

*Windrush Millennium Centre*

*70 Alexandra Road, Moss Side, M16 7WD*

*Tel: 0161 226-9562 Fax: 0161 226-7947 Mobile: 07511608915*

*Email:* [*admin@acmhs-blackmentalhealth.org.uk*](mailto:admin@acmhs-blackmentalhealth.org.uk)

**AFRICAN AND CARIBBEAN MENTAL HEALTH SERVICES**

**Equality and Diversity Monitoring Form**

The African and Caribbean Mental Health Services operates an equal opportunity policy. The information in this section is strictly confidential and is covered by the Data Protection Act 2003.

***Please tick one of the boxes***

**Are you** Male   Female  Other

**Is your gender identity the same as the gender you were assigned at birth?**

Yes  No  Prefer not to say  Not known

**Which of the following options best describes how you think of yourself?**

Heterosexual/straight  Gay  Lesbian   Bisexual

Transgender  Woman (inc trans woman)  Man (inc trans man)  Not known/unsure  Other  Prefer not to say

**Age** 18 – 20   21 – 30   31 – 40   41 - 50  51 – 60  61 - 70  71 – 80  81+

**Marital status**

Single  Married  Civil partnership  Separated

Divorced  Widowed  Living with partner  Prefer not to say

**Are you currently pregnant or have had a baby in the last 12 months?**

Yes  No  Prefer not to say

**Faith/Religion/Beliefs**

Christian  Catholic  Judaism  Buddhism  CofE  Sikhism  Rastafarian  Hinduism Islam  Muslim  Other  None  Prefer not to say

**Employment status**

Full-time   Part-time  Volunteer  Student   Unemployed  Homemaker  Retired  Military veteran Self employed  Prefer not to say

**Homeless Drug history**

Yes  No  Prefer not to say  Yes  No  Prefer not to say

**Forensic history**

Yes  No  Prefer not to say

**Disability**

A disabled person is defined in the Disability Discrimination Act 2005 as someone with a physical or mental impairment that has a substantial and long term impact on their ability to carry out day to day activities. This definition also covers HIV, cancer, multiple sclerosis, hearing, oral or learning impairment and any progressive or life long conditions.

*Having read this, do you consider yourself to be covered by the definition?*

Yes  No  Prefer not to say

If yes, please tick the relevant box/es

Mental health  Physical disability  Hearing impairment

Learning disability  Sight impairment  Long term health condition

Dementia  Autism  Other

*If specific arrangements are required or to declare a statement of disability, please state here:*

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**Choose one section from A to F, then tick the appropriate box to indicate your cultural background:**

|  |  |  |
| --- | --- | --- |
| **A: Black, Black British, Black European, Black Scottish or Black Welsh**  Caribbean   African  Any other Black background, please specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **B: Mixed**  White and Black Caribbean  White and Black African  White and Asian  Any other Mixed background, please specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **C: Asian, Asian British, Asian European, Asian Scottish or Asian Welsh**  Indian   Pakistani  Bangladeshi  Any other Asian background, please specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **D: White**  British   European  Scottish  Welsh  Irish  Any other White background, please specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **E: Chinese, Chinese British, Chinese European, Chinese Scottish, Chinese Welsh or other ethnic group**  Chinese  Any other Asian background, please specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **F: Any other ethnic group**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |