**Mayfair Community Care Referral Form**

**Section 1: Basic Information**

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| **Service User’s Name**: | | | **Date of birth**: | | | **Gender**: | |
| **Phone No**: | | |
| **National Insurance No**: | | | **Date of application:** | | | **Nationality:** | |
| **Expected Discharge/Release Date:** | |  |  | | |  | |
| **Date Supported Living Required:** | |  |  | | |  | |
| **Current address**: | | | | | | | |
| **Next of Kin** | | | | | | | |
| Who is your next of kin? Please give contact details:  Name:  Address:  Phone Number: Email: | | | | | | | |
| **Reason for Referral** | | | | | | | |
| What is their current housing situation? Reasons for seeking supported living? | | | | | | | |
| Please give details of any problems they may have that have led to losing their accommodation in the past: | | | | | | | |
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| **PRESENTING ISSUES – PRIMARY (TICK ONE ONLY)** | | | | | | | |
| Mental Health/Personality Disorder | | | | | | |  |
| Learning Disability | | | | | | |  |
| Physical Disability | | | | | | |  |
| Alcohol Misuse | | | | | | |  |
| Drug Misuse | | | | | | |  |
| Care Leaver | | | | | | |  |
| Homelessness | | | | | | |  |
| **PRESENTING ISSUES – SECONDARY (TICK ALL THAT APPLY)** | | | | | | | |
| Mental Health/Personality Disorder | | | | | | |  |
| Learning Disability | | | | | | |  |
| Physical Disability | | | | | | |  |
| Alcohol Misuse | | | | | | |  |
| Drug Misuse | | | | | | |  |
| Care Leaver | | | | | | |  |
| Homelessness | | | | | | |  |
| Other: | | | | | | |  |
| **Describe how they cope in the following areas:**  **H = High, M = Medium, L = Low, N = None** | | | | | | | |
| Budgeting |  | | Paying Bills | |  | | |
| Accessing Benefit |  | | Domestic Life Skills | |  | | |
| Personal Hygiene |  | | Health & Safety in the home | |  | | |
| Escorting |  | | Accessing Social & Recreational Activities | |  | | |
| Language and or Literacy |  | | Accessing to Education & Employment | |  | | |
| Behaviour/Anger Management |  | | Medication/Prescriptions | |  | | |
| Registering with Primary Care Services |  | | Physical Health Care Problems |  | | | |
| Nutrition/Weight |  | | Family Mediation |  | | | |
| Neighbours/Peer Mediation |  | | Vulnerable to Exploitation |  | | | |
| Mobility |  | | Religious/Cultural |  | | | |
| Have any applications for long-term housing (for example: council housing, housing associations, etc.)? If so, please give details: Please list all addresses in the last 5 years? | | | | | | | |
| Previous Addresses: (including name and contact details of establishment)   |  |  | | --- | --- | | Year 1: | Year 4: | | Year 2: | Year 5: | | Year 3: | Other: | | | | | | | | |

**Section 2 – Health Needs**

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| **Mental Health Needs: please list inclusive of diagnosis and medications:** | | | | |
| **NHS Number:** | | | | |
| Mental illness/mental health needs: | | | | |
| Please list diagnosis and medications: | | | | |
| Are they entitled to 117 after care? (please ask them) | | | | |
| **Prescription medication? Please provide full list of all medications and state what they are for including dosage:** | | | | |
| **Medication:** | **Dosage** | | **Reason** | **Duration taken** |
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| **Mental Capacity:** | | | | |
| Is there Mental Capacity issues? | *supply further information including frequency, triggers, last episode* | | | |
| Has a Mental Capacity Test | *supply further information including who completed Test and date* | | | |
|  | *supply further information including and triggers* | | | |
| **SUCIDE : (if Care Coordinator or Social Worker involved they will have information)** | | | | |
| Suicidal ideation | *supply further information including frequency, triggers, last episode* | | | |
| Attempts to end life? | *supply further information including frequency, triggers, last episode* | | | |
| Significant dates that can trigger relapse in mental state. | *supply further information including and triggers* | | | |
| **Self-Harming Behaviours: (if Care Coordinator or Social worker involved they will have information)** | | | | |
| Have they ever deliberately self-harmed? | *supply further information including frequency, triggers, last episode* | | | |
| How do they self-harm? | *supply further information including frequency, triggers, last episode* | | | |
| Self-harming method? | *supply further information including frequency, triggers, last episode* | | | |
| Self-harming Triggers? | *supply further information including frequency, last episode* | | | |
| Has this led to hospitalisation? | *supply further information including frequency, triggers, last episode* | | | |
| Date of Last Episode: | *supply further information including frequency, triggers, last episode* | | | |
| **Physical Health needs and please list and diagnosis and medications:** | | | | |
| Drug misuse: | | | Alcohol: | |
| Criminal behaviour: | | | Violence: | |
| Illness: | | | Disability: | |
| Gambling | | | Other | |
| **Professional Support Network:** Please give details of any other agencies or supportive organisations involved, including names and contact details | | | | |
| 1. | | | **2.** | |
| 3. | | | 4. | |
| 5. Former GP - Dates | | | 6. Former GP - Dates | |
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| **Criminal convictions? Please list ALL convictions with dates:** | | | | |
| **Have they ever been under any form of supervision? Please tick relevant box:**  [ ] Probation [ ] Suspended sentence [ ] Supervision order [ ] Parole [ ] Care order [ ] Care programme | | | | |
| **Are they in custody? Please give details:**  Release date: | | | | |
| **Section 3: Risk Assessment** | | | | |
| Statement from Referring agency: | | | | |
| Please state how long you have known/worked with the applicant? | | | | |
| What capacity have you known the applicant? | | | | |
| Please provide details of any restrictions or orders placed on the person? Such as Tag, or Community Treatment Order (CTO), S37/41 Ministry of Justice. (MOJ). | | | | |
| **Details of any restriction orders placed on the applicant, tick box and provide detail:**  [ ] Tag [ ] Community Treatment Order (CTO [ ] S37/41 Ministry of Justice (MOJ) [ ] Other [ ] Care | | | | |
| Are they open to secondary mental health services and please give information on past assessments/treatments and history to include length involvement and any Hospital admissions? | | | | |
| **Risk Assessment**  Please rate High, Medium, Low or N/A | | | | |
| Arson | |  | | |
| Physical Violence (to others) | |  | | |
| Verbal Aggression | |  | | |
| Damage to Property | |  | | |
| Alcohol Abuse | |  | | |
| Drug/Substance Abuse | |  | | |
| Sexual Behaviour (risk to others) | |  | | |
| Self Harm/Overdose | |  | | |
| Criminal Behaviour | |  | | |
| Sleep Disturbance/Nocturnal Difficulties | |  | | |
| Other | |  | | |
| Explanation of Any Risks Presented: | |  | | |
| **Financial**: What funding and support is available to them? | | | | |
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| **Any Other Relevant Information** |
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| **Name of Referrer:**  **Job Title:**  **Tel No:**  **Mobile No:**  **Email:**  **Agency Name & Address:**  **Signed Referring Agency:**  **Date:** |

**Please email securely to** [**info@mayfaircare.org.uk**](mailto:info@mayfaircare.org.uk)