**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)

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| Year 1: | Year 4: |
| Year 2: | Year 5: |
| Year 3: | Other: |

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**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**