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| This referral form is for use only by practitioners making a referral to the Outreach Barnet specialist mental health floating support service.  |

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| **Client Details** |
| Surname: | Enter text here. | First Name: | Enter text here. |
| Date of Birth: | Enter a date here. | NI Number: | Enter text here. |
| Address: | Enter text here. |  |  |
| Postcode: | Enter text here. | Contact Number(s): |  |
| Gender: |[ ]  Male |[ ]  Female | Religion or Belief: | Choose an item. |
| Ethnic Origin: | Choose an item. | If ‘Other’, please state: | Enter text here. |
| Language Support Required: |[ ]  Yes |[ ]  No | Language: | Enter text here. |
| Circumstance: |
|[ ]  Frail elderly |[ ]  Older Person Mental Health |
|[ ]  Older Person with support needs |[ ]  Generic |
|[ ]  Mental Health problems |[ ]  Mentally disordered offenders |
|[ ]  Physical Disability |[ ]  Young People at risk |
|[ ]  Sensory Impairment |[ ]  Young People leaving care |
|[ ]  Offenders or at risk of offending |[ ]  Teenage parents |
|[ ]  Drug problems |[ ]  Single homeless with support needs |
|[ ]  Alcohol problems |[ ]  Homeless families with support needs |
|[ ]  Women at risk of domestic violence |[ ]  Refugees |
|[ ]  Learning Disabilities |[ ]  Other – please state: Enter text here. |

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| Current accommodation: |
|[ ]  Owner-occupied |[ ]  Residential care |
|[ ]  Rented council |[ ]  Sheltered housing |
|[ ]  Rented housing association |[ ]  Hospital |
|[ ]  Rented privately |[ ]  Sleeping rough / precariously-housed |
|[ ]  Temporary accommodation |[ ]  Other - please state: Enter text here. |

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| Is the applicant aware of the referral? |[ ]  Yes |[ ]  No |

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| **Next of Kin Details** |
| Surname: | Enter text here. | First Name: | Enter text here. |
| Contact Number(s): | Enter text here. |  |  |

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| **Brief Outline of Client’s Circumstances** |
| *e.g. physical / mental health, disability / mobility, substance misuse, ability to cope, single or part of household, child protection / safeguarding issues, etc. Please ensure to provide information about the client’s diagnosis and treatments.* |
| Enter text here. |

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| **Risk Assessment** |
| *Please complete as fully as possible – missing information will delay the process. The referring practitioner’s* ***full risk assessment form*** *should also be completed and attached with this referral form.* |
| Have you met the client: |[ ]  Yes |[ ]  No | Consent form attached (see end): |[ ]  Yes |[ ]  No |
| From your knowledge, is there any reason why the tenant should not be visited alone? *(if “Yes”, please mark any of the boxes below that are applicable to the tenant and give details. Please also indicate if the tenant has any special requirements, e.g. sign language / Braille, or cultural requirements.)* |[ ]  Yes |[ ]  No |
|[ ]  History of violence / aggression | Please give details and provide report if available: |
|[ ]  Verbally abusive / intimidation / threatening behaviour | Enter text here. |
|[ ]  Self harm / suicidal |  |
|[ ]  At risk from others |  |
|[ ]  Sexual abuse |  |
|[ ]  Gender issues |  |
|[ ]  Arson or fire risk |  |
|[ ]  Substance misuse |  |
|[ ]  Other, e.g. Child Protection issues |  |

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| **Referring Organisation / Agency / Source** |
|[ ]  Care Management (Social Services) |[ ]  MAPPA |
|[ ]  Secondary Mental Health Service |[ ]  MARAC |
|[ ]  Care Programme Approach |[ ]  Child In Need |
|[ ]  Probation Service |[ ]  Child Protection |
|[ ]  Youth Offending Team |[ ]  Child In Care |
|[ ]  Drug Interventions Programme (DIP) |[ ]  Care Leaver |
|[ ]  Anti-Social Behaviour Order |[ ]  Primary Care |
| Who is the lead contact? |[ ]  Person completing this form |[ ]  Other (please state details below) |
| Name: | Enter text here. | Role: | Enter text here. |
| Contact Number(s): | Enter a date here. | Email Address: | Enter text here. |

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| **Current Care / Support** |
| *Including Social Services, Mental Health services, GP / NHS, drug / alcohol services, housing officer, support worker, home carers, voluntary agency workers, family / friends / neighbours.* |
| Name: | Address / Contact Number(s): | Relationship: |
| Enter text here. | Enter text here. | Enter text here. |
| Enter text here. | Enter text here. | Enter text here. |
| Enter text here. | Enter text here. | Enter text here. |
| Enter text here. | Enter text here. | Enter text here. |

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| **Outcomes – please note, the duration of our service is usually 4 months** |
| Choose from the following list the intended outcomes of support: |
|[ ]  Maximise income including applying for welfare benefits, e.g. UC, HB, CTB, JSA, IS. |[ ]  Help with maintaining personal safety and security in the home e.g. locks, smoke alarms, having appliances switched off. |
|[ ]  Reducing debt, e.g. rent, CT, credit card. |[ ]  Accessing cultural, religious and general networking also, befriending groups. |
|[ ]  Obtain paid work. |[ ]  Better manage substance misuse issues. |
|[ ]  Participate in training or education. |[ ]  Access housing repairs. |
|[ ]  Participate in informal learning activities. |[ ]  Access more appropriate accommodation. |
|[ ]  Participate in leisure/cultural/faith activities. |[ ]  Maintain accommodation and avoid eviction. |
|[ ]  Participate in work-like activities, e.g. unpaid/voluntary work/work experience. |[ ]  Help comply with statutory orders in relation to offending behaviour. |
|[ ]  Establish contact with external services / groups / friends / family. |[ ]  Access assistive technology/aids and adaptations. |
|[ ]  Better manage physical health. |[ ]  Avoid causing harm to others. |
|[ ]  Better manage mental health. |[ ]  Minimise harm/risk of harm from others. |
|[ ]  Help to access other services e.g. voluntary services, day centres, Environmental Health Services, meal services, Assist, Home Library service, Occupational Therapy Team, Disabled Badge Scheme, CAB, gardening services, Handy Persons Scheme, Dial a Ride, etc. |[ ]  Develop confidence and ability to have greater choice and / or control and / or involvement. |
| Free text box. |

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| **Referrer Details** |
| Name: | Enter text here. | Role: | Enter text here. |
| Agency: | Enter text here. | Contact Number(s): | Enter text here. |
| Address: | Enter text here. |
| Email Address: | Enter text here. |
| Date: | Enter a date here. |

**Please submit this form by double-clicking on the “Send Form” button below. Please note, you will need to attach the client’s completed consent form, and your own completed full risk assessment form to your email:**

Outreach Barnet

Barnet Homes

Barnet House

1255 High Road

London

N20 0EJ

Email: outreachmentalhealth@barnethomes.org

Telephone: 020 8359 5225

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| Download Customer Consent Form here: |  |