|  |  |
| --- | --- |
| Referee Details | |
| Name: |  |
| Address: |  |
| Postcode: |  |
| Date of Birth: |  |
| NHS Number: |  |
| Telephone Number: |  |
| Registered GP Surgery: |  |
| Employment Status: |  |

|  |  |
| --- | --- |
| Referrer’s Details | |
| Name: |  |
| Job Title: |  |
| Team and Location: |  |
| Organisation: |  |
| Telephone Number: |  |
| Email Address: |  |

|  |
| --- |
| How did you (the referrer) know/hear about the service? |
|  |

If you are a referrer from an organisation other than 2gether Trust or an NHS GP, please complete the external referrer information section below:

|  |  |  |
| --- | --- | --- |
| External Referrer’s Additional Information | | |
| Are you a registered charity? | 🗆Yes | 🗆No |
| If yes, please provide your charity number: |  | |
|  | | |
| Please confirm how long the referee has been known to your organisation? | | |
|  | | |
| How long have you, as the referrer, known the referee? **\*** | | |
|  | | |

**\*Please Note:** We will only accept referrals from external referrers if the referee has been known by your organisation for a MINIMUM of 6 months.

|  |  |  |
| --- | --- | --- |
| STAFF – INTERNAL USE ONLY | | |
| Date Referral Received: |  | |
| Has the Referrer and Referee been contacted within 4 days? | 🗆Yes | 🗆No |

|  |  |
| --- | --- |
| Referee Emergency Contacts (Please provide a MINIMUM of two) | |
| **Next of Kin\*** |  |
| Name: |  |
| Relationship: |  |
| Phone Number: |  |

|  |  |
| --- | --- |
| Name: |  |
| Relationship: |  |
| Phone Number: |  |

|  |  |
| --- | --- |
| Name: |  |
| Relationship: |  |
| Phone Number: |  |

**\*Please Note:** If you are a referrer from an organisation other than 2gether Trust or an NHS GP we will need to contact the referee’s Next of Kin prior to offering a stay to ensure our emergency procedures are in place.

|  |  |
| --- | --- |
| Reason for Referral (Please only tick ONE option) | Please Tick |
| Break from Family |  |
| Social Isolation |  |
| Anniversary and/or Time of Year |  |
| Recent Crisis and/or Trauma |  |
| Break from Current Situation |  |
| Part of Wellbeing Plan |  |
| Low Mood and/or Anxiety |  |
| Low Stimulus Needed |  |
| Step Down |  |

|  |
| --- |
| Please provide further information on the reason for referral: |
|  |

|  |
| --- |
| Current Medication  (please list current medication) |
|  |
| Medication Management  (i.e. can the referee manage medication independently?) |
|  |
| Accommodation Issues  (i.e. can the referee return back to current accommodation during or after a stay at our service?) |
|  |
| Physical Health Needs  (i.e. Diabetes, Mobility, Visual, and/or Auditory Impairment etc.) |
|  |
| Mental Health Needs  (i.e. Nature of Illness, etc.) |
|  |
| Drug and/or Alcohol Dependency  (i.e. dual diagnosis, can the referee be abstinent from drugs and alcohol during their 2 weeks stay with us?) |
|  |

|  |  |
| --- | --- |
| Clinical Risk Assessment Attached? (Please attach a clinical risk assessment within the last month) | |
| Yes | No |
| If no, please explain why: | |
|  | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Risk Factors | | | | | |
|  | | | | | |
| A. Potential Risk to Self | | |  | | |
| High |  | Medium |  | Low |  |
| B. Potential Risk to Others | | | | | |
| High |  | Medium |  | Low |  |
| C. Identified Risk Indicators: | | | | | |
|  | | | | | |
| Forensic History  Past (Up to 1 year ago) | | | | | |
|  | | | | | |
| Present  (Within the last year) | | | | | |
|  | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Overall Risk Rating | | | | | |
| High |  | Medium |  | Low |  |
| When completing the following sections, please include any relevant previous history as well as current information. | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Risk of Harm to Self | | | | | |
| High |  | Medium |  | Low |  |
|  | | | | | |
| Suicide Attempt | | | Suicidal Ideation | | |
| Self Injury or Harm | | | Self Neglect | | |
| **Evidence:** | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Risk of Harm From Others | | | | | |
| High |  | Medium |  | Low |  |
|  | | | | | |
| Adult Safeguarding | | | Domestic Abuse | | |
| Risk of Psychological Harm  (including bullying) | | | Risk of Financial Abuse | | |
| Risk of Physical Harm | | | Risk of Sexual Exploitation | | |
| **Evidence:** | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Risk of Harm to Others | | | | | |
| High |  | Medium |  | Low |  |
|  | | | | | |
| Exploitation of Others | | | Fire Setting | | |
| Multi-Agency Public Protection Arrangements (MAPPA) | | | Risk to Children and/or Vulnerable  Adults | | |
| Sexual Assualt | | | Violence, Aggression and/or Abuse  to Family | | |
| Violence, Aggression and/or Abuse  to General Public | | | Violence, Aggression and/or Abuse  to Staff | | |
| Weapons | | | Criminal Record | | |
| **Evidence:** | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Risk of Accidents | | | | | |
| High |  | Medium |  | Low |  |
|  | | | | | |
| Accidental Harm Outside of Home  (i.e. wandering). | | | Driving/Road Safety | | |
| Unsafe Use of Medication | | | Falls | | |
| **Evidence:** | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Other Risks | | | | | |
| High |  | Medium |  | Low |  |
|  | | | | | |
| Absconding/Escape | | | Damage and/or Theft to Property | | |
| Incidents Involving the Police | | | Hoarding | | |
| Other | | | **If other, please specify:** | | |
| **Evidence:** | | | | | |

|  |
| --- |
| Summary |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| I confirm that all information is true and correct to the best of my knowledge: | | | |
| **Name:**  (Please Print if possible ): |  | **Date:** |  |
| **Signature:** |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| In line with GDPR Regulations, I confirm that the person being referred provides consent for the referrer to contact the Alexandra Wellbeing House and for Alexandra Wellbeing House to contract the person being referred: | | | |
| **Name:**  (Please Print if possible ): |  | **Date:** |  |
| **Signature:** |  | | |

|  |  |
| --- | --- |
| Please Send Completed Form To: | |
| **Secure Email:** | [sg.mind@nhs.net](mailto:sg.mind@nhs.net) |
| **Postal Address:** | The Alexandra Wellbeing House  29-31 Alexandra Road  Gloucester  GL1 3NY |

**If you have any queries, please do not hesitate to contact us via the following details:**

[alexwellbeing@sgmind.org.uk](mailto:alexwellbeing@sgmind.org.uk)

01452 245338