|  |  |
| --- | --- |
| 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 Gloucestershire Health and Care NHS Foundation 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 Gloucestershire Health and Care NHS Foundation 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 note:**

an assessment will be booked within 14 days of the referral being received. Please ensure that you are able to attend the assessment with the person being referred within this timeframe. The referral will be closed if we are unable to assess within 14 days.

If you are GP sending in a referral we request that the person being referred attends with a close friend or family member if possible.

Thank you.

|  |  |
| --- | --- |
| 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 3DR |

**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