Please read the below prior to completing the form:

* Most of our services are free to access for residents of the Swindon Borough Council area only, if you live outside of this area there may not be services available to you or there may be a cost involved in accessing specific services.
* To ensure we can process your referral as quickly as possible please check that the form is fully completed, signed and dated before submitting it.
* On receipt of the referral we aim for a Wellbeing Coordinator to make initial contact with you within 2 weeks.
* We will make contact via a telephone call, the number you should expect a call from is 01793 432031.
* If we are unsuccessful in speaking with you after three attempts we will assume you no longer require the service.

|  |  |  |  |
| --- | --- | --- | --- |
| Your Personal Details: | | | |
| Name: |  | Date of Birth: | / / |
| Address: |  | | |
| Postcode: |  | | |
| Phone Number: |  | | |
| Mobile Number: |  | | |
| Email Address: |  | | |

|  |
| --- |
| Mental health diagnosis or concern: |
|  |
| Where did you hear about us? |
|  |

The support we offer follows the 5 Ways to Wellbeing model of Connect, BeActive, Take Notice, Keep Learning and Give. Please tick below the services you would like to access:

|  |  |  |  |
| --- | --- | --- | --- |
| CONNECT | | | |
| Meeting New People |  | Developing Social Skills |  |
| Joining Local Clubs/Groups |  | Faith/culture based activities |  |

|  |  |  |  |
| --- | --- | --- | --- |
| BEACTIVE | | | |
| Walking Group |  | Yoga |  |
| Sports and Leisure |  | Developing independence |  |

|  |  |  |  |
| --- | --- | --- | --- |
| TAKE NOTICE | | | |
| Pursue hobbies or interests |  | Self-harm counselling |  |
| Creative Activities |  | Self-esteem and confidence building |  |

|  |  |  |  |
| --- | --- | --- | --- |
| KEEP LEARNING | | | |
| Exploring training/education |  | Courses e.g. Maths |  |
| Advice and Guidance |  | Support from other agencies |  |

|  |  |  |  |
| --- | --- | --- | --- |
| GIVE | | | |
| Volunteering opportunities |  | Employment or work experience |  |
| Developing skills |  | Explore Peer Mentoring |  |

|  |  |  |
| --- | --- | --- |
| Do you have a history of the following? (please tick) | | |
| A. Self-Harm | Yes | No |
|  |  |
| B. Self-Neglect | Yes | No |
|  |  |
| C. Suicide Attempts | Yes | No |
|  |  |
| D. Drugs Misuse (including prescription medication) | Yes | No |
|  |  |
| E. Committing Criminal Offences | Yes | No |
|  |  |
| If you answered yes to ‘E’ please provide further details: | | |
|  | | |

|  |  |  |
| --- | --- | --- |
| Have you recently left hospital? | Yes | No |
|  |  |
| If you answered yes to the above please provide further details: | | |
|  | | |

We require the below information as it may be necessary for us to seek further information in the event there are concerns regarding your health or in the event of an emergency.

|  |  |  |  |
| --- | --- | --- | --- |
| Next of Kin or Emergency Contact | | | |
| Name: |  | Relationship to you: |  |
| Address: |  | | |
| Phone Number: |  | | |
| Mobile Number: |  | | |
| Email Address: |  | | |

|  |  |
| --- | --- |
| Your GP: | |
| Doctor: |  |
| Surgery Name: |  |
| Phone Number: |  |

|  |  |
| --- | --- |
| Your CPN/Support Worker: | |
| Name: |  |
| Organisation: |  |
| Phone Number: |  |

|  |  |
| --- | --- |
| Other Support/Agency: | |
| Name: |  |
| Organisation: |  |
| Phone Number: |  |

Equal Opportunities Monitoring

|  |  |  |  |
| --- | --- | --- | --- |
| Ethnicity: | | | |
| White | | Mixed | |
| British |  | White & Black Caribbean |  |
| Irish |  | White & Black African |  |
| Other white background (please state) |  | White and Asian |  |
| Other mixed background |  |
| Asian or British Asian | | Black or Black British | |
| Indian |  | Caribbean |  |
| Pakistani |  | African |  |
| Bangladeshi |  | Other background |  |
| Chinese |  | Other Asian Background |  |
| Religion: | | | |
| Christian |  | Catholic |  |
| Sikh |  | Hindu |  |
| Muslim |  | Other (please state) |  |
| None |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Gender: | | | |
| Male |  | Female |  |
| Transgender |  | Other |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Sexual orientation: | | | |
| Heterosexual |  | Bisexual |  |
| Homosexual |  | Other (please state) |  |
| Lesbian |  | Prefer not to say |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Registered Disabled: | | | |
| Yes |  | No |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Status: | | | |
| Single |  | Divorced /Separated |  |
| Married |  | Widow |  |
| Co-habiting |  | In a relationship |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Accommodation: | | | |
| Council housing |  | Owned Property |  |
| Private Rental |  | Housing Association |  |
| Supported Housing |  | Other |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Employment Status: | | | |
| Full-time employment |  | Part-time employment |  |
| Student |  | Volunteering |  |
| Retired |  | Unemployed |  |

|  |  |  |
| --- | --- | --- |
| Other people in your household: | | |
| Name | DOB (if under 18) | Relationship to you |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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

|  |  |
| --- | --- |
| Please Send Completed Form To: | |
| Email: | [admin@swindonmind.org](mailto:admin@swindonmind.org) |
| Postal Address: | Sanford House  Sanford Street  Swindon  SN1 1HE |