

Referral form



Important

- This is the referral form for the vocational recovery and work retention services.
- We accept referrals from general practitioners and secondary mental health professionals. We also accept self-referrals from individuals.

How to complete

- To assess referrals accurately as well as ensure the safety of our clients and staff, it is essential this referral form is completed thoroughly. We will not be able to accept incomplete referral forms.
- There are 5 sections to complete on this referral form:
 1. About the client
 2. About the referrer
 3. The clinical team
 4. Relevant background information
 5. Risk assessment
- Please include all relevant documentation such as the client's care plan.

How to submit

–For security reasons, we only accept referrals via post or email. Send the referral and any additional documentation to:

Via post: **Referrals Administrator**
The Cellar Trust
Farfield Road
ShIPLEY
BD18 4QP

Via email: referrals@thecellartrust.org

When submitting referral via email

1. Password protect the document and send.
2. Send the password in a separate email.

What happens after you make a referral?

- Once we receive a referral we will confirm receipt via email.
- We operate a waiting list for our vocational recovery service however we endeavour to see everyone as quickly as possible.
- You can follow your referral by contacting

E: referrals@thecellartrust.org

T: 01274 588002

1. About the client

Title:	First name:	Surname:
Date of birth:	Emergency contact:	
Permanent address:	Emergency contact address:	
Post code:	Emergency contact post code:	
Phone:	Emergency contact phone:	
Mobile:	Relationship to client:	
Email:		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Sexuality: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Not stated	
Ethnic Origin:	<input type="checkbox"/> White British	<input type="checkbox"/> White Irish
<input type="checkbox"/> Other White	<input type="checkbox"/> Mixed White & Black African	<input type="checkbox"/> Mixed White & Asian
<input type="checkbox"/> Mixed White & Black Caribbean	<input type="checkbox"/> Other mixed	<input type="checkbox"/> Asian / Asian British Indian
<input type="checkbox"/> Asian / Asian British Pakistani	<input type="checkbox"/> Asian / Asian British Bangladeshi	<input type="checkbox"/> Other Asian
<input type="checkbox"/> Black / Black British Caribbean	<input type="checkbox"/> Black / Black British African	<input type="checkbox"/> Any other Black background
<input type="checkbox"/> Chinese	<input type="checkbox"/> Any other ethnic background	<input type="checkbox"/> Not stated
Which service are you referring the client to?		
<input type="checkbox"/> Vocational recovery	For people over 18, who are out of work with moderate to severe, and/or enduring mental health problems who want to work towards a specific goal such as education, training, voluntary or paid work.	
<input type="checkbox"/> Work retention	For people over 18, who are in work but on sick leave who need support to return to work.	
Where does the client wish to be seen?		
<input type="checkbox"/> Shipley (Farfield Rd, BD18)	<input type="checkbox"/> Bradford city centre	<input type="checkbox"/> Keighley (BD22) <input type="checkbox"/> Skipton (BD23)

2. About the referrer

Title:	First name:	Surname:
Organisation:	Job role:	
Address:	Phone:	
Post code:	Date of referral:	
Referrer's email:		

We will email you to confirm receipt of this referral form.

3. The clinical team

GP name:	GP surgery:
Address:	Phone:
Post code:	Email:

3. The clinical team (continued)

Psychiatrist/Care Coordinator name:	
Address:	Phone:
	Email:
Post code:	

4. Relevant background information

Mental Health diagnosis:

Summary of the impact this is having on their life:

Does the client have any other health problems/disabilities and how might these impact on their ability to engage with our service? Are any reasonable adjustments needed?

Are these other health problems/disabilities secondary to their mental health problem? No Yes

If no, please give details:

Has the client used our vocational recovery or work retention service before? No Yes

If yes, when was this and what has changed since the client last attended?

Which of the following benefits does the client receive?

<input type="checkbox"/> JSA	<input type="checkbox"/> ESA (wrag)	<input type="checkbox"/> PIP		
<input type="checkbox"/> ESA (support)	<input type="checkbox"/> IB	<input type="checkbox"/> IS	<input type="checkbox"/> DLA	<input type="checkbox"/> UC

Does this person need to be seen by two workers? No Yes

If yes, please give details:

Does this person need to be seen by a specific gender of staff? No Yes

If yes, please give details:

Are there any other support factors which we need to consider? No Yes

If yes, please give details:

5. Risk assessment

Date of assessment:

Completed by:

Is the client on CPA?

No Yes

If yes, have you attached the CPA?

No Yes

Harm to self	Current (in the last 6 months)		Historical (ever)	
Act with suicidal intent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Self harm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Suicidal ideation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, please give details:

Harm to others	Current (in the last 6 months)		Historical (ever)	
Sexual exploitation/assault	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Violence/aggression (any)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Risk to children (including Schedule 1)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Exploitation (financial/other)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stalking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Risk to vulnerable adults	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, please give details:

Harm from others	Current (in the last 6 months)		Historical (ever)	
Exploitation/abuse (sexual/financial)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emotional/psychological abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Violence/aggression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Risks of medication/treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, please give details:

Accidents	Current (in the last 6 months)		Historical (ever)	
Accidents in the home	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Misuse of medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Accidents outside the home	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Driving/road safety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, please give details:

Other risks	Current (in the last 6 months)		Historical (ever)	
Police involvement (any)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inappropriate contact (calls/visits)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MAPPA	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex offender	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TILT high risk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Probation service involvement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Damage to property/theft	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CTO	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, please give details:

Factors affecting risk	Current (in the last 6 months)		Historical (ever)	
Substance misuse (alcohol/drugs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Risk of losing essential services	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Major Life Event	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Current Mental State	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ability to summon help	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Refusal/Disengagement of services	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Discontinuation of medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Client unaware of risk (to self/others)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, please give details: