**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:

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| Via post: | **Referrals Administrator**The Cellar TrustFarfield RoadShipleyBD18 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

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| 1. **About the client**
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| **Title:** | **First name:** | **Surname:** |
| **Date of birth:** | NHS Number: |
| **Permanent address:** | Emergency contact: |
|  | Emergency contact address: |
| **Post code:** | Emergency contact post code: |
| **Phone:** | Emergency contact phone: |
| **Mobile:** | Relationship to client: |
| **Email:** |
| **Gender:**  | [ ]  Male | [ ]  Female | **Sexuality:** | [ ]  Heterosexual | [ ]  Bisexual | [ ]  Gay | [ ]  Lesbian | [ ]  Not stated |
| **Ethnic Origin:** | [ ]  White British | [ ]  White Irish |
| [ ]  Other White | [ ]  Mixed White & Black African | [ ]  Mixed White & Asian |
| [ ]  Mixed White & Black Caribbean | [ ]  Other mixed | [ ]  Asian / Asian British Indian |
| [ ]  Asian / Asian British Pakistani | [ ]  Asian / Asian British Bangladeshi | [ ]  Other Asian |
| [ ]  Black / Black British Caribbean | [ ]  Black / Black British African | [ ]  Any other Black background |
| [ ]  Chinese | [ ]  Any other ethnic background | [ ]  Not stated |
| **Which service are you referring the client to?** |
| [ ]  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. |
| [ ]  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?** |
| [ ]  Shipley (Farfield Rd, BD18) | [ ]  Bradford city centre | [ ]  Keighley (BD22) | [ ]  Skipton (BD23) |

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| 1. **About the referrer**
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| **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.

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| 1. **The clinical team**
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| **GP name:** | **GP surgery:** |
| **Address:** | **Phone:** |
|  | **Email:** |
| **Post code:** |  |

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| 1. **The clinical team (continued)**
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| **Psychiatrist/Care Coordinator name:** |
| **Address:** | **Phone:** |
|  | **Email:** |
| **Post code:** |  |

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| 1. **Relevant background information**
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| **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?** | [ ]  JSA | [ ]  ESA (wrag) [ ]  PIP |
| [ ]  ESA (support) | [ ]  IB | [ ]  IS | [ ]  DLA [ ]  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:** |

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| 1. **Risk assessment**
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| **Date of assessment:** | **Completed by:** |
| **Is the client on CPA?** | [ ]  No | [ ]  Yes |
| **If yes, have you attached the CPA?** | [ ]  No | [ ]  Yes |

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| **Harm to self** | Current (in the last 6 months) | Historical (ever) |
| Act with suicidal intent | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Self harm | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Suicidal ideation | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| **If yes, please give details:** |
| **Harm to others** | Current (in the last 6 months) | Historical (ever) |
| Sexual exploitation/assault | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Violence/aggression (any) | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Risk to children (including Schedule 1) | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Exploitation (financial/other) | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Stalking | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Risk to vulnerable adults | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| **If yes, please give details:** |
| **Harm from others** | Current (in the last 6 months) | Historical (ever) |
| Exploitation/abuse (sexual/financial) | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Emotional/psychological abuse | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Violence/aggression | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Risks of medication/treatment | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| **If yes, please give details:** |
| **Accidents** | Current (in the last 6 months) | Historical (ever) |
| Accidents in the home | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Misuse of medication | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Accidents outside the home | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Driving/road safety | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| **If yes, please give details:** |

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| --- | --- | --- |
| **Other risks** | Current (in the last 6 months) | Historical (ever) |
| Police involvement (any) | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Inappropriate contact (calls/visits) | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| MAPPA | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Sex offender | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| TILT high risk | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Probation service involvement | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Damage to property/theft | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| CTO | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| **If yes, please give details:** |
| **Factors affecting risk** | Current (in the last 6 months) | Historical (ever) |
| Substance misuse (alcohol/drugs) | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Risk of losing essential services | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Major Life Event | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Current Mental State | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Ability to summon help | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Refusal/Disengagement of services | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Discontinuation of medication | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| Client unaware of risk (to self/others) | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| **If yes, please give details:** |