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| NOTE: This is the **clinical referral form** to be completed by general practitioners and secondary mental health professionals wishing to refer clients onto the Pathways to Employment service.  Individuals wishing to access employment support should use the **self-referral form** which can be found on our website at:  <https://www.thecellartrust.org/what-we-do/how-to-access-our-services/> |

**How to complete and submit the form**

* Please complete this form as accurately and clearly as possible ensuring it is checked thoroughly before submission to avoid possible delays in accessing the service.
* If you have any difficulty completing this form please contact us on **01274 588002** and we will be happy to help you.
* For security reasons, we can only accept referrals via post or email. Please send the completed referral form and any relevant documentation to:

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| Via post: | **Pathways to Employment Team** The Cellar Trust Unit 12, Park View Court St Paul’s Road Shipley, West Yorkshire BD18 3DZ |
| Via email: | [referrals@thecellartrust.org](mailto:referrals@thecellartrust.org) |

* When submitting a referral via email please ensure you complete the following:

1. Password protect the document before sending.
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 Pathways to Employment service and as a result waiting times to access the service can vary.
* You can follow the progress of your referral by contacting:

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| **How we use your data** |
| *In order for us to support you we need to record some of your personal details which may also contain sensitive information. We process your personal data in line with the General Data Protection Regulation (GDPR) and you are able to withdraw your consent to us holding your data at any time (unless there is a legal reason for us keeping it). More details can be found in our Privacy Policy and Client Privacy Notice – available from a member of staff or on our website:* [*www.thecellartrust.org/privacy/*](http://www.thecellartrust.org/privacy/) |

E: [referrals@thecellartrust.org](mailto:referrals@thecellartrust.org) T: 01274 588002

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| 1. **About the client** | | | | | | | | |
| **First name:** | | | | | | **Surname:** | | |
| **Date of birth:** | | | | | | NHS Number: | | |
| **Permanent address:** | | | | | | National Insurance Number: | | |
|  | | | | | | Emergency contact: | | |
| **Post code:** | | | | | | Relationship to client: | | |
| **Phone:** | | | | | | Emergency contact address: | | |
| **Mobile:** | | | | | | Emergency contact post code: | | |
| **Email:** | | | | | | Emergency contact phone: | | |
| **Gender:** | Male | Female  Transgender Male  Transgender Female  Non-binary  Other | | | | | | |
| **Sexuality:**  Heterosexual or straight  Bisexual  Gay  Lesbian  Asexual  Pansexual  Other  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 | |
| **Religion:**  Christian  Catholic  Buddhist  Hindu  Jewish  Muslim  No religion  Sikh  Other  Prefer not to say | | | | | | | | |
| **Language:** What is the client’s main/preferred language? (*Please state*) | | | | | | | | |
| **Is the client a Carer?** (not including dependent children) Yes  No | | | | | | | | |
| **Does the client have any dependents?**  Yes  No | | | | | | | | |
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| **Which service is the client referring to?** | | | | | | | | |
| Pathways to Employment | | | For people aged 16 and over, who are **unemployed and 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 employment. | | | | | |
| Work retention | | | For people aged 16 and over, who are currently **employed** **but on sick leave** who need support to return to their place of work, or are **at the risk of being off sick.** | | | | | |
| **Which location/area would the client prefer to be seen?** | | | | | | | | |
| Shipley | | | | Bradford city centre | | Keighley (BD22) | | Skipton (BD23) |

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| 1. **About the referrer** | |
| **First name:** | **Surname:** |
| **Organisation:** | **Job role:** |
| **Address:** | **Phone:** |
| **Post code:** | Date of referral: |
| **Referrer’s email:** | |

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| 1. **Doctors details** | |
| **GP name:** | **GP surgery:** |
| **Address:** | **Phone:** |
| **Post code:** | **Email:** |

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| 1. **Clinical team (if applicable)** | |
| **Psychiatrist/Care Coordinator name:** | |
| **Address:** | **Phone:** |
| **Post code:** | **Email:** |

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| 1. **Relevant background information** | | | | | |
| **Mental Health diagnosis:** | | | | | |
| **Summary of the impact their mental health has on their day-to-day life:** | | | | | |
| **Does the client have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?**  Yes  No  **If yes, do any of their conditions or illnesses reduce/limit their ability to carry out day-to-day activities?**  Yes – limited a lot  Yes – limited a little  No  Prefer not to say  **If they have any physical health conditions/illnesses, are they secondary to their mental health conditions?**  *If no, please provide details*  Yes  No  **Are any reasonable adjustments needed?** | | | | | |
| **Has the client used our Pathways to Employment/Work Retention service before?**  Yes  No  **If yes, when was this and what has changed since the client last attended?** | | | | | |
| **Which of the following benefits does the client receive?** | | | | | |
| Job Seekers Allowance | | Personal Independence Payment | Universal Credit | | |
| ESA (Support group) | ESA (Work related group) | | Disability Living Allowance | | Income Support |
| **Does the client need to be seen by two workers?** | | | | Yes | No |
| **If yes, please give details:** | | | | | |
| **Does the client need to be seen by a specific gender of staff?** | | | | Yes | No |
| **If yes, please give details:** | | | |  |  |
| **Are there any other support factors which we need to consider?** | | | | Yes | No |
| **If yes, please give details:** | | | | | |

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

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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:** | | | | |