

Please read carefully the following notes as they are intended to help you decide if the referral is appropriate. Please fully complete the form.

Criteria

- 1 S2R provides services to adults aged 18 to 64 who live in Kirklees.
- 2 Persons referred should have a primary diagnosis of mental health needs.
- 3 The person's individual needs should have been assessed as potentially benefiting from our services.

Notes

S2R provides community mental health services for residents of Kirklees.

S2R does have an expectation that those individuals referred will have had their needs assessed, and where a referral to S2R is being considered that we are involved in the care planning process.

Please provide a copy of the most recent Care Plan and the most recent Risk Assessment.

S2R assumes that this referral form will be completed in co-operation with the person referred. Please indicate if this is not the case and why.

S2R has a confidentiality policy which includes individual's access to records. (This normally includes the referral form).

The information in this form will be used by S2R for the purposes of service delivery, as stipulated under the CPA and monitoring of equal opportunities.

S2R accepts the use of Direct Payments and Personal Budgets for services. Please contact us if you require more information about this.



About the person being referred:

Name:		DOB:
Address:		
Post Code:		
Tel no:		
Mobile:		
Ethnicity:	Gender: (M/F)	

Registered on CPA	CPA attached	Risk Assessment attached
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> Section 117	<input type="checkbox"/> No	<input type="checkbox"/> No

About the referrer:

Name:	
Tel no:	mobile:
Involvement(GP, CMHT) :	
Will your support be continuing? Y / N	Will you accompany above to S2R? Y / N

Other workers involved:

Keyworker: (main contact)	
Tel no:	mobile:
Role (CPN, SW) :	
GP: Tel:	Psychiatrist: Tel:
Surgery:	Team:
Other workers/Agencies involved:	

Name of next of kin and relationship:
Address:
Tel no:

Has referred ever served in Armed Forces?	Y / N
Is referred a war veteran?	Y / N

When would the person referred prefer to attend? (Please tick)

- Weekdays Evenings Weekends

Support Needs Identified / Activities Requested

- 1 Social inclusion/recreation (Drop In/leisure groups/craft/photo group)
- 2 CBT Workshops (Stress/Anxiety/Confidence & Self-esteem/
Assertiveness/Gender/Cultural specific issues)
- 3 121/counselling
- 4 Employment advice (training/voluntary work/I.T./literacy)
- 5 Exercise (gym/swim/football/yoga/relaxation/allotment/walking group)
- 6 Anger Management
- 7 Other? (Please specify)

Diagnosis (Diagnosis and nature of mental health indicated as part of past and current risk status)

--

Relevant medical information

--

Risk Low Medium High

If medium or high please give more detail:

--

Funding Information

Has the referred person been informed about Direct Payments?	Y	N
Is this person eligible for a Direct Payment or Personal Budget?	Y	N
Is this person in receipt of a Direct Payment or Personal Budget?	Y	N

Signed Referrer..... **Date**.....

Signed by Referred..... **Date**.....

For Office use only

Database:	Welcome Session/IA:
Contact sheet:	Sc: Letter: