Oxfordshire Mental Health Partnership Referral Form

This form is for use throughout Oxfordshire to make referrals to existing Mental Health support services. This can be filled in by you or for someone else.

This form is for initial entry into Mental Health Services. If you are already known to anyone in the partnership you do not need to fill in this form as we will use your passport assessment.

People wishing to refer to non-Mental Health floating support services should contact Connection (01865 711267) to get a copy of their generic referral form.

Please complete this form in full. In order to ensure we are able to safely offer the correct type of support and accommodation we require full and frank disclosure of mental health history including all risk areas. Unless we are satisfied that we have sufficient information to this end we will not carry out an assessment.

Some services may require an up to date copy of your CPA and Risk assessment. Please see pages 3–4 to check what to include. **Failure to include the documents requested will delay your application.**

Supported Housing

Please tick the boxes below to show which service you wish to be considered for

☐ **Response Recovery Campus**

☐ **Oxfordshire Mind Transitional Housing Recovery Service**

Oxford City ☐ South Oxfordshire ☐ West Oxfordshire ☐

☐ **Response Area Teams**

Please indicate in which area of Oxfordshire you would like to be considered for housing -

Oxford City ☐ North Oxfordshire ☐

☐ **Response Oxfordshire Care and Support Services**

Address: Referrals Co-ordinator
Mind Response Housing Partnership
AG Palmer House
Morrell Crescent
Oxford OX4 4SU

Email: support@mindandresponse.org.uk
Telephone: 01865 397951
Fax: 01865 397941 (please call to confirm receipt)
Websites: www.response.org.uk
www.oxfordshire-mind.org.uk

Floating Support Services

☐ **Connection the Floating Support Team**

Telephone: 01865 711267 **Email:** enquiries@connectionsupport.org.uk
Website: http://www.connectionfs.org.uk

☐ **Elmore Mental Health Floating Support Team**

☐ **Complex/Multiple Needs Floating Support**

Telephone: 01865 200130 **Email**: info@elmorecommunityservices.org.uk
Website: http://www.elmorecommunityservices.org.uk

Please send your form to and clearly state which service you are applying for on the front:

Address: 213 Barns Road (1st Floor),
Oxford,
OX4 3UT

Mental Health Recovery Groups and Education

☐ **Restore Recovery Groups, Training and Employment Coaching**

Telephone: 01865 455823 **Email**: referral@restore.org.uk
Website: https://www.restore.org.uk/

A. Details of Person Wanting Support

Is this a self referral? **YES** ☐ **NO** ☐

Applicants Details

Name of person wanting support: (Mr,Mrs,Miss,Ms…) _____

Date of Birth: _____ NHS number: _____

Address:

Contact Address (if different):

Telephone No: _____ Mobile No: _____

E-mail address: _____

Which area of Oxfordshire do you have a local connection with?

Referred By:

Name: _____

Service: _____ Job Title: _____

Telephone No: _____ Mobile No: _____

E-mail: _____

Family and Friends involved in your support:

Name: _____	Name: _____
Relation to you: _____	Relation to you: _____
Telephone No: _____	Telephone No: _____
Mobile No: _____	Mobile No: _____
E-mail address: _____	E-mail address: _____

Details of any current services/carers involved in supporting you:

Name: _____	Name: _____
Service: _____ Job Title: _____	Service: _____ Job Title: _____
Telephone No: _____	Telephone No: _____
Mobile No: _____	Mobile No: _____
E-mail address: _____	E-mail address: _____

Included with this referral–

☐ A GP letter stating diagnosis, any medication I am taking and any further information they feel is relevant. (This is to be provided if you are not currently being supported by Mental Health services.)

Or

☐ A copy of current CPA, stating cluster number.

☐ A copy of the applicant's most recent Risk Assessment.

If this information is not provided your application will be delayed until we receive it.

B. Reason for Referral

Please tick the appropriate box for the level of support you need

Managing mental health ☐	Physical health and self care ☐	Addictive Behaviour ☐
Living Skills ☐	Social Networks ☐	Responsibilities ☐
Work ☐	Relationships ☐	Trust and Hope ☐
Identity and Self Esteem ☐		

Please comment on the boxes you ticked.

C. Wellbeing

Mental Health services have a holistic approach and aim to support people's physical health What is the date of your last annual physical health review?

Do you drink alcohol? Yes ☐ No ☐ Do you smoke? Yes ☐ No ☐

If so how much? _____ If so how much? _____

Do you take non-prescription drugs? Yes ☐ No ☐

If yes, please provide details:

Please give details of any physical health needs you have which we need to consider?

Height: _____

Weight: _____

BMI: _____

Are you on the SMI Chronic Disease Register at your local GP Practice? **YES** ☐ **NO** ☐ **UNSURE** ☐

Were there any physical health risks identified at the last review?

Will a care package be required? If so, has one already been applied for?

Do you exercise or wish to receive support to undertake exercise?

D. Extra information on finances

Are you in receipt of benefits?

ESA ☐ PIP/DLA ☐ Other (please state)

Are you eligible for Housing Benefit?

Do you have outstanding debts/arrears? Please give details.

Do you have any savings or assets? What are they?

Do you have a bank account?

If so, are you willing to pay your housing service charge by standing order?

You can have a benefits check by calling Benefits for Better Mental Health on 07754 999 411.

E. Is there any history of the following (tick for yes)

Alcohol Misuse	☐	Drug Misuse	☐	Sexual offences	☐
Suicide attempts	☐	Self Harm	☐	Verbal abuse	☐
Physical Violence	☐	Destruction of property	☐	Criminal convictions	☐
Fire risk	☐	Arson	☐	Domestic Violence	☐
Safeguarding issues	☐	Anti-Social Behaviour	☐	Being Exploited	☐
Rent arrears	☐	Loss of tenancy	☐		

Please give details on all those ticked:

F. Medication

Please give details of any current medication that you are taking?

Do you look after your own medicine? YES ☐ NO ☐

Do you understand what your medication is for and what possible side-effects it may have?

Have you ever had problems with taking your medication?

Are there any medications or drugs that you have a known sensitivity to?

G. Mental Health

What are your past and present mental health problems?

What care cluster have you been allocated? (Please note that to be eligible for these services you must be in care cluster 4-17).

Please tell us about all previous/current hospital admissions.

Has a Doctor told you your diagnosis? YES ☐ NO ☐
What is this diagnosis?

Do you agree with the diagnosis?

H. Summary of Current Housing situation and reason for referral

Home Owner	☐	Private Landlord	☐	Sofa Surfing	☐
Homeless	☐	Living with Parents	☐	Housing association	☐

Are you on the council housing register? **YES** ☐ **NO** ☐

I. Employment

Employed	☐	Other (In Education or Training)	☐	Unemployed and seeking work	☐
Retired	☐	Homemaker	☐	Not receiving benefits	☐
Unpaid Voluntary work	☐	Long term sick or disabled receiving benefits	☐		

Weekly hours worked

1-4 hours	☐	5-15 hours	☐	16-29 hours	☐	30+ hours	☐

J. Your Marital status

Married	☐	Civil Partnership	☐	Single	☐	Separated	☐	Not Disclosed	☐
Not Known	☐	Divorced/Dissolved	☐	Widowed	☐				

L. Future Goals

What are your future goals? (E.G. housing, employment or personal)

Equal Opportunities Monitoring Form

We are committed to providing a service which is fair and available to everyone. To help us monitor this, please answer the following questions:

Gender Male ☐ Female ☐ Other Gender Identity ☐

Do you consider yourself to have a disability? Yes ☐ No ☐

Ethnicity of applicant

A. White	British	☐
	Irish	☐
	Other	☐
B. Mixed	White & Black Caribbean	☐
	White & Black African	☐
	White & Asian	☐
	Other	☐
C. Asian	Indian	☐
	Pakistani	☐
	Bangladeshi	☐
	Other	☐
D. Black	Caribbean	☐
	African	☐
	Other	☐
E. Chinese or other ethnic group		
	Chinese	☐
	Other	☐
F. Refugee		☐

Appendix 1

Information for applicants

Once you have completed this form, you may send it or copies of it, to any of the services whose details you will find on pages 2. Where you have said that you are happy for your information to be shared with other agencies, we will do this. By doing this, we hope to save you the time and trouble of filling this and other forms out more than once.

Once the services get your form, they may ask for more information and they will be back in touch to do this. Once they have sufficient information, and are confident that you are eligible for their service, they will be in touch to arrange an interview. The interview will be your chance to ask more questions and for the service to decide whether they can offer you support.

Each of the services using this form has their own standards and complaints procedures which you can use to appeal if you think the decision they have made is wrong or unfair. Call any of the numbers on page 2 for more details of how to do this.

Not all of the services may be right for you, so please call any of the providers to check whether the support they can offer is the support that you need. If you would like more details on what services are available you can call the Oxfordshire Mental health information line on 01865 247788 or by looking at www.omhp.org.uk.

In order to ensure we assess your needs appropriately, we reserve the right to share relevant confidential information with those involved in providing social and health services as would be expected as part of normal professional, confidential working practice. We may also share such information with other agencies when accepting or making a referral and/or where there is a risk to you or to others. By signing this form you are agreeing to the above and all personal information will be treated as confidential and subject to the Data Protection Act 1998, by all services. You may, at any time, request access to the personal information held about you.

We may also need to obtain relevant reports or information from sources other than the referees you have provided and by signing this form you give us permission to do so.

If you do not wish to share the information on this form, or to provide details which will support your application, we may not be able to accept your application.

Please take note, we cannot process the referral without the applicant's signature.

Your name:

_____

Signature of applicant

_____

Date _____

Your supporter/referrer's name:

_____

Signature of supporter

_____

Date _____

☐ I have supported the applicant to complete this form