

**PRIVATE AND CONFIDENTIAL**

# Black Country Suicide Bereavement Support Service



## Referral Form

Referral			
Are you making a self-referral?  YES/NO	Are you making this referral on behalf of someone else?  If yes please include your: Name: Position:  Relationship to the client: Contact Address:  Contact Number:		

Title:		Address:	
Name:			
Surname:			
Date of birth:			
Age:			
Landline:		Mobile:	
Can we leave a voice message?		Yes	No
Can we text you		Yes	No
Would you like to receive information from The Kaleidoscope Plus Group via email? (We will only send information related to this service and you can ask us to stop at any time) If yes please state which email address should be used:			
GP information:		Who should we contact in an emergency?	
GP name/ Practice:		Name:	
Practice address:		Relation to you:	
Postcode:		Contact number:	

**Please return to The Kaleidoscope Plus Group, 321 High Street, West Bromwich, West Midlands, B70 8LU**

or [sppark@kaleidoscopegroup.org.uk](mailto:sppark@kaleidoscopegroup.org.uk)

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Telephone number:	
Do you have any medical conditions we need to know about? If yes, please specify:	
Please outline the primary reason for making the referral:	
What are your hopes in relation to how we will be able to support you?	
Please provide any additional information that you feel may be relevant:	

Monitoring is a vital part of helping us to shape our services. The information that you provide is confidential and is used anonymously for The Kaleidoscope Plus Group’s monitoring outcomes only. No personal details will be divulged to any third party. Thank you

<b>How would you describe your ethnic origin? (Please tick)</b>				
1. White British	<input type="checkbox"/>	10. Asian/ Asian British Bangladeshi	<input type="checkbox"/>	
2. White Irish	<input type="checkbox"/>	11. Asian / Asian British Other	<input type="checkbox"/>	
3. White Other	<input type="checkbox"/>	12. Black/ Black British Caribbean	<input type="checkbox"/>	
4. Mixed White & Black Caribbean	<input type="checkbox"/>	13. Black/ Black British African	<input type="checkbox"/>	
5. Mixed White & Black African	<input type="checkbox"/>	14. Black/ Black British Other	<input type="checkbox"/>	
6. Mixed White & Asian	<input type="checkbox"/>	15. Chinese	<input type="checkbox"/>	
7. Mixed Other	<input type="checkbox"/>	16. Other ethnic group	<input type="checkbox"/>	
8. Asian/ Asian British Indian	<input type="checkbox"/>	17. Refused to disclose	<input type="checkbox"/>	
9. Asian/ Asian British Pakistani	<input type="checkbox"/>		<input type="checkbox"/>	
<b>Gender?</b> (Please tick)	Male	<input type="checkbox"/>	Transgender	<input type="checkbox"/>
	Female	<input type="checkbox"/>	Other	<input type="checkbox"/>
<b>How would you describe your sexuality?</b> (Please tick)	Heterosexual (Straight)	<input type="checkbox"/>	Not sure	<input type="checkbox"/>
	Homosexual (Gay)	<input type="checkbox"/>	Not known	<input type="checkbox"/>
	Bi-sexual	<input type="checkbox"/>	Not stated	<input type="checkbox"/>

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<b>What is your first language?</b>				
<b>How would you describe your religion or beliefs?</b> (please state)				
<b>Do you consider yourself to be disabled?</b> If yes, please specify	Physical disability		Mental disability	
	Learning disability		Sensory disability	
<b>Are you a carer?</b> (Please tick)	Yes		No	
<b>Do you have a carer?</b> (Please tick)	Yes		No	
<b>How do you describe your marital status?</b> (Please tick)	Married		Separated	
	Single		Widowed	
	Divorced		Not stated	
<b>Are you currently pregnant or on maternity leave?</b> (Please tick)	Yes		No	
<b>Do you have any children/dependants under 18, living with you?</b>	Yes		No	
<b>What is your work status?</b>	Full-time employed		Part-time	
	Volunteering		Sick	
	Unemployed		Retired	

**Additional Information**

I give my consent for The Kaleidoscope Plus Group to retain this information and understand that it will be stored confidentially and handled in full compliance with the Data Protection Act 1998 and The Kaleidoscope Plus Group's policy on confidentiality.

I understand the importance of keeping staff updated on significant changes in my health and circumstances.

I understand that on occasions staff may request further information/advice from other persons involved in supporting me and I understand that on occasions staff may need to seek help on my behalf which has been explained to me.

Client Signature ..... Date .....

Print name .....

Referrer signature ..... Date: .....

Print name .....

***For office use only:***

UC#:		Name:		Date:	
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