



For better
mental health

Cam-mind

Barrere House
100 Chesterton Road
Cambridge
CB4 1ER
Tel: 01223 311320

Referral Form

Day Services & Befriending Scheme

Introduction

Cam-mind is Cambridge's oldest mental health charity, providing support to people with mental health problems since 1908. 1 in 4 people will experience mental health problems at some point in their lives. Mental health issues can affect anyone, however most people can and do recover. Cam-mind's services are designed to support mental health service users on their road to recovery.

Referral Criteria

- Individuals referred to Cam-mind must have a diagnosed mental health condition.
- Individuals referred must be referred by a professional involved in their care (e.g. GP/Psychiatrist/Social Worker/CPN/Occupational Therapist)
- All applicants should be over 18 years of age and be a willing participant in their referral.

How to complete this form

Please complete **all** sections of this referral form and attach copies of relevant supporting documents (e.g., CPA assessments, discharge summaries, risk assessment details etc). By signing this form, you are agreeing to Cam-mind being provided with such information. When completed, please return to the above address.

Part 1 – to be completed by the client with support from the referrer, if appropriate

Part 2 – to be completed by the referrer in collaboration with the client

Equal Opportunities

Cam-mind aims to provide a quality service to all those who satisfy our criteria. The referral assessment is dependent solely on the needs of the individual and the capacity of Cam-mind to work with them, in line with our Equal Opportunity Policy. Any information which is requested, other than that which is required for the needs assessment is for statistical and reference purposes only.

Confidentiality

All information supplied in the referral process is strictly confidential. It will not be passed on to third parties without the consent of both the client and the referrer, except where it is considered that there is a significant risk to the client or to another individual.

PART 1: To be completed by client

Client Details

Title (e.g. Mr/Mrs/Miss/Ms): _____

Full name: _____

Address: _____

Postcode: _____

Tel: _____ Mobile Tel: _____ Email: _____

Date of Birth: _____ First language: _____

How would you describe your ethnic origin? : _____

Name of GP: _____ GP Tel: _____

Aims & expectations

What are your expectations of Cam-mind? _____

Cam-mind is keen to provide the best service possible, so we may ask you to comment informally from time to time about our services. Please indicate whether you would be happy to do this YES NO

From time to time Cam-mind will publish photographs taken at our events/groups. Please tick box if you do not wish your photograph to be used

Health matters

How would you describe your mental health at the moment and how does this affect you?

Do you have any physical problems or disabilities that we should be aware of? If yes, please give details:

Cam-mind services

Day Services - Please circle the group/s you are interested in attending.

* Please note that some of our groups may have waiting lists.

Mon

Textiles & Craft Course
Evening Social Club
OCD Support Group

Wed

Poetry
Women's Group
Sawston Social Club

Fri

Allotment Group
Fri Social Club
Arbury Social Club
Football Club

Tues

Art
Poetry
Pottery

Thurs

Cookery Course
Pottery
Evening Social Club

Sun

Sunday Bistro

Befriending scheme – Befriending volunteers meet individuals on a regular basis who have become particularly isolated due to their mental health.

Are you interested in being considered for a befriender? (Please Circle): YES NO

If you have answered yes, what goals do you think befriending might help you to achieve?

PART 2:

Referrer Details

Full name: _____ Professional Status: _____

Address: _____

Tel: _____ Mobile: _____

As part of our ongoing service to the client, Cam-mind would like to continue to have contact with the person who is referring and be kept informed of any relevant reviews or changes in circumstances.

PLEASE INFORM US IF YOU CEASE TO WORK WITH A CLIENT YOU HAVE REFERRED TO US.

Reason for referral

Please give details: _____

Does the Care Programme Approach apply? YES NO

A REFERRAL WILL NOT BE ACCEPTED IF A CPA IS IN USE AND IT IS NOT SUPPLIED OR IF THIS QUESTION IS UNANSWERED.

Has the client been diagnosed with any of the following? Please tick as appropriate.

Anxiety		Schizophrenia		Anorexia Nervosa	
Depression		Post-natal depression		Bulimia Nervosa	
Bi-polar Disorder (Manic depression)		Psychotic depression		Other (Specify Below)	
OCD		Personality disorder			

Professional contacts

Please provide details of other professionals/support workers involved with the client below:

JOB TITLE: _____

JOB TITLE: _____

Name: _____

Name: _____

Tel: _____

Tel: _____

Address: _____

Address: _____

Frequency of contact: _____

Frequency of contact: _____

Period of working with client: _____

Period of working with client: _____

JOB TITLE: _____

JOB TITLE: _____

Name: _____

Name: _____

Tel: _____

Tel: _____

Address: _____

Address: _____

Frequency of contact: _____

Frequency of contact: _____

Period of working with client: _____

Period of working with client: _____

Risk assessment

1. Is there a history of substance/ alcohol misuse? YES NO
If yes, please give relevant details (inc dates) _____

2. Is there a history of suicide attempts? YES NO
If yes, please give relevant details (inc dates) _____

3. Is there a history of violence to others? YES NO
If yes, please give relevant details (inc dates) _____

4. Is there a history of severe self neglect? YES NO
If yes, please give relevant details (inc dates) _____

5. Is there a history of self harm? YES NO
If yes, please give relevant details (inc dates) _____

6. Is there a history of inappropriate sexual behaviour? YES NO
If yes, please give relevant details (inc dates) _____

7. Is there a history of the client being seriously exploited? YES NO
If yes, please give relevant details (inc dates) _____

8. Do you know of any threatening behaviour which may indicate a serious risk? YES NO
If yes, please give relevant details (inc dates) _____

In the unlikely event of an emergency who would you like us to contact?

Name: _____

Address: _____

Telephone No.: _____

Mobile/Work No: _____

Signature of client:	Date:
Signature of referrer:	Date: