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|  | **Bromley Community Mental Health Service****Referral Form** |
| **Bromley Community Mental Health Service Eligibility Criteria:**To be eligible for this service each crieria below needs to met. Please tick all that apply to you/client☐ Adult (over 18 years of age)☐ Bromley resident☐ Receiving specialist mental health care and treatment in the community☐ No family member or friend to act as an appropriate person to facilitate the individual’s involvement in the decision making about their care and support. If you feel unsafe and need urgent help, please call 999 immediately |
| **How to contact us**  | **If you cannot fill in this form, please click view then edit.**If youneed helpwith this form, please call us on: **0345 310 1812 and option 2 for referrals**  |
| **Send referral by Email** | **referrals@advocacyforall.org.uk** | **Send referral by** **Post** | **The Civic Centre, St Mary’s Road, Swanley BR8 7BU** |
| **Client information** |
| **Full name** | Click or tap here to enter text. | **Date of birth** |  Click or tap here to enter text. |
| **Your address at the time of referral** |  Click or tap here to enter text. | **Age** |  Click or tap here to enter text. |
| **Your permanent address** | Click or tap here to enter text. | **Gender** | Man ☐ Woman ☐ Transgender ☐ Non Binary ☐ Intersex ☐ Prefer not to say ☐ Your own term: Click or tap here to enter text. |
| **Your Location at the time of referral** | Own Home ☐ Residential Home ☐ Nursing Home ☐ Supported Living ☐ Independent Living ☐ Sheltered Housing ☐ Living With Parents ☐ Shared Lives ☐ Other ☐ Click or tap here to enter text. | **Disability/impairment****Please tick all that apply** | ADHD ☐ Autism (ASC) ☐ Cognitive Impairment ☐ Learning Disability ☐ Mental Health ☐ Physical disability ☐ Sensory (Hearing) ☐ Sensory (Sight) ☐ Serious Physical illness ☐ Any Other ☐ Click or tap here to enter text. |
| **Telephone** |  Click or tap here to enter text. |
| **Mobile** |  Click or tap here to enter text. | **Care Manager, Social Worker or Mental Health Support Worker details** | Name: Click or tap here to enter text.Telephone: Click or tap here to enter text. |
| **Email** | Click or tap here to enter text. | **Funding area** |  Click or tap here to enter text. |
| **Emergency Contact Name:** | Click or tap here to enter text. | **Emergency Contact Relationship:** | Click or tap here to enter text. |
| **Emergency Telephone Number:** | Click or tap here to enter text. |  |  |

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| **Ethnicity** |  |  |  |  |  |
| **White** | British | ☐ | **Black or** **Black British** | Caribbean | ☐ |
|   | Irish | ☐ | African | ☐ |
|   | Other | ☐ |  | Other | ☐ |
| **Mixed** | White & Black Caribbean | ☐ | **Asian or** **Asian British** | Indian | ☐ |
|   | White & Black African | ☐ | Pakistani | ☐ |
|   | White & Asian | ☐ |   | Chinese | ☐ |
|   | Other  | ☐ |   | Other | ☐ |
| **Other** |  Click or tap here to enter text. |   |  |  |  |
| **Sexuality** | Choose an item. | **Religion** | Choose an item. |
| **Referrer information (do not complete if self-referral)** |
| **Name of Referrer**  | Click or tap here to enter text. | **Address** | Click or tap here to enter text. |
| **Relationship to personfor example, key worker, social worker, family member** | Click or tap here to enter text. |
| **Telephone**  | Click or tap here to enter text. |
|  | **Email**  | Click or tap here to enter text. |
| **Referral issue – please give a brief outline of the reason advocacy is required.**Click or tap here to enter text. |

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| **Are there any risks we should be aware of when visiting or arranging to meet the client?**If you are not aware of any risks, please write 'no known risks'Click or tap here to enter text. |
| **How did you hear about us?** Click or tap here to enter text. |

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| **Consent Form**The Data Protection Act says we need to make sure you agree that we can keep personal information on you. |

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| **I would like Advocacy for All to advocate for me. I understand that my information will be stored safely on a computer.** |
| **Your signature.****Type in name if completing online** | Click or tap here to enter text. | **Date** | Click or tap here to enter text. |
| **The** **referrer’s agreement** |
| **I confirm that I have consent from the client to make a referral to Advocacy for All or I confirm I have the authority to make a referral for the client. I understand that the information I provide about the client will be stored securely on a computer.**   |
| **Referrer signature.****Type in name if completing online** | Click or tap here to enter text. | **Date** | Click or tap here to enter text. |

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| **What happens next:** We won’t tell anyone what you have said to us unless* you want us to
* it involves danger to you or other people
* the laws say we need to
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| **Advocacy for All is an Independent Advocacy Organisation Charity No: 1068455 Company No: 3407428** |

