**Barnet Friends**

**Referral Form**

**Client’s Details – ALL FIELDS MUST BE COMPLETED**

Personal data collected by CB Plus will be used for administrative purposes. If you are not suitable for support in this instance your details will be passed to a provider more suitable and your assessment notes may be passed to them as well. Please make sure that the person you are referring has agreed to the referral.

**Please tick to agree to this statement** 🞎

|  |
| --- |
|  |

**Referral Date:**

**Client details**

|  |  |  |  |
| --- | --- | --- | --- |
| Full name: |  | Address:  Postcode:  Email: |  |
| Title: |  |
| Sex: | Male 🞎 Female 🞎 Other 🞎  *(please specify):* |
| Date of Birth: |  | Contact Tel: |  |

**Client next of kin or emergency contact**

|  |  |  |  |
| --- | --- | --- | --- |
| Full name: |  | Address:  Postcode: |  |
| Title: |  |
| Gender: | Male 🞎 Female 🞎 Other 🞎  *(please specify):* |
| Relationship to client: |  | Contact Tel:  Email |  |

**GP Surgery**

**Please make the client aware we will contact their GP and call 999 if we are concerned about their personal safety**

|  |  |
| --- | --- |
| Practice name: | |
| Address: | |
| Contact number: | Email address: |

**Reasons for Referral**

|  |  |
| --- | --- |
| Regular chat over the telephone/ befriending |  |
| Signposting to other services |  |
| Where did you hear about our service? |  |

**Ethnicity/Communication**

|  |
| --- |
| Ethnicity: |
| Do not wish to disclose 🞎 |
| Sexual Orientation: |
| Do not wish to disclose 🞎 |
| Does the person have any communication problems such as with language, illiteracy, hearing or visual impairments? Please give details: |
| Preferred language: |

**Risk Assessment and Further Information** (this is so we can make sure you receive the right support that you need)

Please note we are unable to provide (clinical) support to clients:

-Living with a severe mental health diagnosis

-Experiencing psychotic episodes

-Being treated for addictions

-Receiving treatment from Community based NHS mental health teams, as well as

those who have been sectioned in the last 6 months

|  |  |
| --- | --- |
| Can contact be made to the client’s home by telephone? |  |
| Does the client know that they are being referred and consented to this referral? |  |
| Does the client live alone?  If no, please specify who with: |  |
| Are there any current mental health concerns? |  |
| Has the client experienced suicidal thoughts? |  |
| IS there any history of mental health concerns or substance abuse? |  |

**Referrer’s Details (If not self-referring)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | Address |  | |
| Occupation/  Relationship |  |
| Tel |  | Postcode |  | |
| Email |  | | | |
| **Signed** |  | | Date |  |

**Return this form by email to: befriending@cbplus.org.uk**

**Telephone: 020 8016 0016**