**Help When You Need It Referral & Triage Form**

**This box for office use. After referral has been assessed please categorise as below:**

|  |  |  |
| --- | --- | --- |
|  |  | Tick as appropriate |
| Red | Needs immediate key work and support |  |
| Amber | access to wider service /waiting list for key working |  |
| Green | Advice & Assistance  |  |
| Date referral received |  | assessment completed by |  | Date completed |  |

**General completion points**

* To be carried out by the service within 10 days of receiving referral/enquiry.
* Allow 30 minutes for completion.
* Brief overview of service, what to expect if they are eligible, timescales etc.
* Where possible, staff to feed questions sensitively into a wider conversation piece about the individual

**Details of Referrer**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Relationship to Applicant |  |
| Email |  | Contact Number |  |
| Job Title |  | Organisation |  |
| Address |  | Do you consider this referral to be an emergency? |  |
| If Yes, please state why |  |
| Signature of referrer |  | Date |  |

Who should we contact about this referral in the first instance? **Referrer/Applicant**

**Self-Referral / Applicant’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Title |  | Applicant name |  |
| Date of Birth |  | National Insurance Number |  |
| Current address |  |
| Contact number |  | email |  |

**Children and other people living with you are part of your household**

|  |  |  |
| --- | --- | --- |
| Name | Relationship | DOB |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of applicant (if self-referring) |  | Date |  |

**Communication**

|  |  |  |  |
| --- | --- | --- | --- |
| How did you hear about our service? |  | Communication preference. Phone, email, other? |  |

**Equalities information**

|  |  |
| --- | --- |
| Age |  |
| Gender |  |
| Sexuality |  |
| Nationality (egg UK) |  |
| Ethnicity (egg Black British) |  |
| Disability |  |
| Religion |  |
|  |  |
|  |  |

**More about you**

1. What type of accommodation do you currently live in?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Tick |  | Tick |
| Council Tenancy |  | Housing Association tenancy |  |
| Private rented |  | Owner occupier |  |
| Friends/ family |  | Sheltered Housing |  |
| Supported Accommodation/ hostel |  | Temporary or emergency accommodation |  |
| Hospital |  | other |   |

1. Do you identify as having a mental health condition? Yes/No

If yes:

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have a diagnosis? |   | Are you engaged with any MH services? | No  |
| Are you on mediation? Name/ dosage/ frequency  |   |
| Name and details of GP, CPN, Recovery Navigator, social worker |  |
| How does your MH affect your day to day life? |   |

1. Are you currently employed, in education, training or volunteering? Yes/No

|  |  |  |  |
| --- | --- | --- | --- |
| Name of organisation |  | Hours worked/ volunteered |  |
| What you do |  |
| If not currently working, are you in receipt of benefits; which ones? |   |

1. What is your immigration status?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Tick |  | Tick |
| UK/Irish Citizen |  | EU Citizen |  |
| Asylum Seeker |  | Refugee status |  |
| Indefinite leave to remain |  | Limited leave to remain  |  |
| Visa (Please state)  |  | Other (please state)  |  |
|  |  |  |   |

1. Do you have recourse to public funds? Yes/no
2. Do you have any support mechanisms eg. Friends, family? Yes/No

|  |  |  |
| --- | --- | --- |
| Name | Relationship to you | How they help you. |
|   |  |  |
|  |  |  |
|  |  |  |

**Personal Circumstances**

1. Are you at risk of losing your current home? Yes/ No

|  |  |  |  |
| --- | --- | --- | --- |
| Date on the NOSP (notice to quit the property) |  | Have you been in court previously around this? When? |  |
| Have you received a court date? What happened |  |

1. Do you need support for any of the following:

|  |  |  |
| --- | --- | --- |
| Area of support | Tick  | State current issues faced and how you need ongoing support in this area. |
| To manage my tenancy |  |   |
| Accessing mental health services to stay well  |  |  |
| Accessing other health services to stay well |  |  |
| With managing my money/ benefits to pay my bills or rent |  |  |
| Learning skills to cook, clean or shop |  |  |
| Writing letter, filling in forms and managing mail |  |  |
| Help finding work, education or training |  |  |
| Because I feel unsafe in my own home |  |  |
| To stay in contact with my support network, family or friends |  |  |
| To feel connected to my community |  |  |
| Other |  |  |

**Support Needs**

Please tick all of the ones that describe you:

|  |  |  |  |
| --- | --- | --- | --- |
| Young person or care leaver |  | Living with physical/sensory disability |  |
| Living with mental health issues |  | Drug User |  |
| Alcohol use |  | Rough Sleeper or history or homelessness |  |
| Offender/ Ex offender |  | Living with long-term chronic ill health |  |
| Living with a learning disability |  | Experiencing domestic violence/abuse |  |
| Refugee |  | Current or ex forces |  |

Do you have any other services supporting you at present?

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Organisation | Contact number | email |
|   |  |  |  |
|  |  |  |  |
|  |  |  |  |

What type of support would you be open to having? Tick all that apply

|  |  |  |  |
| --- | --- | --- | --- |
| Face to face |  | Telephone |  |
| Text |  | Zoom/ online  |  |
| Groups |  |  |  |
|  |  |  |  |

What are your 3 priority support areas?

|  |  |
| --- | --- |
| 1 |  |
| 2 |  |
| 3 |  |

**Risk information**

Important: We may not be able to proceed with your referral if the relevant risk information has not been provided.

So that we can carry out an assessment of your needs and support you and others safely, please indicate if any of the below apply to you, including details where a risk has been identified

|  |  |  |
| --- | --- | --- |
| Risk area | Y, N or Unknown | Details, triggers, consequences of the risk.  |
| Abuse/harassment from others |  |  |
| Medication compliance |  |  |
| Accidental harm/self-neglect |  |  |
| Property damage |  |  |
| Risk of being exploited |  |  |
| Exploitation of others |  |  |
| Risk of financial exploitation |  |  |
| Gambling |  |  |
| Known risk to children |  |  |
| Infestations/pests |  |  |
| Risk to staff working alone |  |  |
| History of starting fires |  |  |
| Self-care/hygiene |  |  |
| Hospitalisation  |  |  |
| Self –harm of suicide |  |  |
| Fragility/falls |  |  |
| Sexual offending |  |  |
| Drug use |  |  |
| Alcohol use |  |  |
| Potential/actual violence |  |  |

Any further info?

Please use the box below to add any important info that has not been included above.

|  |
| --- |
|   |

**Consent of applicant**

NB: If you are the referrer and a physical signature cannot be sought, please say that you have obtained verbal consent from the applicant to refer to us and note when this was.

|  |  |
| --- | --- |
| Signature |  |
| Print Name |  |
| Date |  |

**Next Steps**

This form will now be reviewed by the team to see if we can support you with your needs. If eligible for our support, you will be assigned a Support Worker who will contact you to arrange a first check-in meeting.

Where you are not eligible for support we will work with you connect you with right organisation as per our No Wrong Door commitment. The No Wrong Door Principle means that you will be re-directed successfully to the services that will best help you when you need it.

**Who to contact if I have any further questions?**

Email: enquiriesbristolmhfs@mungos.org

Phone Number: 07761528745