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| **REFERRAL FORM** | |
| **Please tick which service(s) you are referring yourself to :**  \*For a full description of each service please:  **visit** www.mindaberystwyth.org,  **email** info@mindaberystwyth.org  **call** 01970 626 225 | **1 to 1 Support**  ☐Wellbeing Support |
| **Group Wellbeing Sessions**  ☐Art ☐Clwb Crefft ☐Creative Hub  \*Our Drop-In service is on Wednesday’s 2-4pm (no referral needed) |

|  |  |
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| **REFERRAL DETAILS** | |
| ☐ Professional Referral | ☐ Self- Referral |
| Referrer’s Name: | Referrer’s Contact Number: |
| Referrer’s Role: | Referrer’s Email: |



|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **CONTACT DETAILS** | | | | | | | |
| **Title:** |  | | | | | **Pronouns:** |  |
| **Name:** |  | | | | |
| **Preferred name/nickname:** | |  | | | | **Date of birth:** | **/ /** |
| **Address:** | | |  | | | | |
| **Contact Number:** | | |  | **Email Address:** |  | | |
| **Preferred language:** | | | Cymraeg ☐ English ☐ ☐ Other (please specify):­­­ |

May we leave you a voice message on your contact number?

May we text you?

May we email you?

May we send you post?

May we say who we are if anyone else answers your phone?

Would you like to be added to our mailing list?

Would you like to receive our newsletter?

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

|  |  |  |  |
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| **Emergency Contact** | | **Relation to you:** |  |
| **Name:** |  | **Telephone number:** |  |

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Tell us about yourself

Please note that referrals cannot be accepted without completion of this section. We will keep this information safe and confidential.

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|  |  |  |  |
| **Gender:**  ☐Male  ☐Female  ☐Non-binary  ☐Prefer to self-describe  ☐Prefer not to say | **Ethnicity:**  ☐Asian  ☐Black  ☐Mixed  ☐White  ☐Other  (Please specify if you wish)  ☐Prefer not to say | **Sexuality:**  ☐Heterosexual/straight  ☐Gay/Lesbian  ☐Bisexual  ☐Prefer to self-describe  ☐Prefer not to say | **Have you ever identified as transgender?**  ☐Yes  ☐No  ☐Prefer not to say |

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| **1. Are you currently living?** | ☐Alone ☐With a partner/spouse ☐With dependent/s  ☐Other (please specify): | | | | | |
| **2. Do you have a carer?** | ☐Yes ☐No | | **3. Are you a carer?** | | ☐Yes ☐No | |
| **4. Are you currently being supported by any other agencies?** | ☐Yes ☐No (If yes please specify)  **5. Are you happy for us to contact any of these agencies about your referral?** ☐Yes ☐No | | | | | |
| **6. Do you have any medical conditions or medication that we need to be aware of?**  ☐Yes ☐No (If yes please specify): | | | | | | |
| **7. Do you have any accessibility needs that we need to be aware of?**  ☐Yes ☐No (If yes please specify): | | | | | | |
| **8. Do you have any history of/current risk of self-neglect, self-harm or suicide?**  ☐Yes ☐No (If yes please specify): | | | | | | |
| **9. Do you have a history of/current alcohol and/or substance (illegal or prescribed) misuse?**  ☐Yes ☐No (If yes please specify): | | | | | | |
| **10. Do you have a history of/ current risk of domestic abuse?**  ☐Yes ☐No (If yes please specify): | | | | | | |
| **11. Are you vulnerable to exploitation from others?**  ☐Yes ☐No (If yes please specify): | | | | | | |
| **12. Can you tell us about any current challenges you are experiencing with your mental health?** | | | | | | |
| **13. Would you like any information from us about other services, including crisis services?** | | | | | | ☐Yes ☐No |
| **14. Do you have any convictions? (Please note, this will not necessarily exclude you from our services)** | | ☐Yes ☐No (If yes please specify): | | | | |
| **15. Would you like any support with legal and/or illegal substance misuse?** | | | | ☐Yes ☐No | | |
| **16. Are you currently concerned about any of your personal relationships?** | | | | ☐Yes ☐No | | |
| **17. Do you feel safe in your home?** | | | | ☐Yes ☐No | | |
| **18. To keep you, other service users, our staff, and the general public safe; is there anything else you feel we need to know?** ☐Yes ☐No (If yes please specify): | | | | | | |



If you are seeking 1-1 support, would you prefer to receive your support (tick as many as you feel comfortable with)

☐At an external location ☐By phone call ☐By text or instant message

☐By video call ☐ Other (please suggest):

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Description automatically generatedHow can we help?

Please let us know which of the following areas you need support with:

☐Improve and maintain mental health ☐Reduce isolation ☐Be part of the local community

☐ Budgeting ☐ Moving home ☐ Access other services ☐ Benefits

☐ Employment ☐ Preventing homelessness ☐ Other (please suggest):

|  |  |  |  |
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| **Data Sharing Authorisation** | | | |
| A picture containing text  Description automatically generatedI understand that the information on this form will be kept confidential by Mind Aberystwyth in accordance with data protection. However, if Mind Aberystwyth, believe that there is significant risk of harm to myself or another person, they may need to divulge or seek further information from other agencies.  Tick to agree ☐ | | | |
| If you are seeking tenancy support:  A picture containing text  Description automatically generatedI agree to the sharing of this information with Supporting People Teams and the organisations that provide and fund the support. Tick to agree ☐ | | | |
| Signed: |  | Date: |  |

