

**Clear Mind Derby Professional Referral Form**

| **Referring Agency Name**  | **Referral details**  |
| --- | --- |
| Name  | Name  |
| Phone Number  | Phone Number  |
| Email  | EmailAddress |

**Referral details**

| D.OB | Ethnicity  |
| --- | --- |
| Gender | Physical Disability  |
| Learning Difficulty  | Mental Health condition  |

Is it safe for us to directly contact the client you are referring?

Yes No



Client is aware of and consents to the referral being made?



Yes

|  |
| --- |

**How can we help?**

**Does anyone else live in the property with the person you are referring?**

(Relationship to referral only needed, if dependents please state ages )

1.

2.

3.

**Please advise of any risk Indicators for Clear Mind to consider.**

**Property**

Any access to property issues Damage to property 

**Person**

**Level of Risk of: please circle or highlight**

| Suicide | High | Medium | Low |
| --- | --- | --- | --- |
| Self Harm | High | Medium | Low |
| Abuse of alcohol/drugs/medication | High | Medium | Low |
| Engaging in risky behaviour | High | Medium | Low |
| Use of aggression/violence | High | Medium | Low |

 At risk of High Medium Low

 violence

 **Coping: please circle or highlight**

| Ability to cope | High | Medium | Low  |
| --- | --- | --- | --- |
| Level of self-care | High | Medium | Low  |

**Please give further detail of any other identified risk / need / anything you think we should know**

|  |
| --- |

**Any other agency involvement**

| Name of Agency  | Reason for involvement  | Contact Name  | Contact Number  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

OFFICE USE ONLY

**================================================================**

**Decision undertaken as a result of the assessment:** *(tick all that apply)*

**To be completed by Clear Mind Staff**

**Risk Assessment Outcome:**

 **Level of Risk:**

| High | Medium | Low  |
| --- | --- | --- |

| Review on \_\_\_\_\_\_\_\_\_\_\_ | Involve Line Manager | Start Safeguarding proceedings  |
| --- | --- | --- |
| No Action needed | Referral to alternative service(s) | Referral to additional service(s) |
| Details of actions taken: |