Affiliated Local Association

Thurrock Mind
Administration
152 Bridge Road, Grays
Essex, RM17 6DB
Tel: 01375 391411
Fax: 01375 389793
Email: reception@thurrockmind.org.uk

REFERRAL FORM

Please indicate service required:

Counselling/Groupwork
Day Services:

- Community Bridge Builders
- Drop-In and Groups
- Befriending

Advocacy

Older Persons Advocacy

Name:	Date of Birth:
Address: Postcode:	Telephone Nos. Home : Work: Mobile No:
Working: Yes No	Privacy Required: Yes No

Care Co-ordinator:	Telephone No:
G.P.	Telephone No:
Other Professionals involved:	

Next of Kin / Significant Person (to be contacted in an emergency or if unwell):	
Name:	Relationship to Client:
Address: Postcode:	
Contact Telephone No:	Mobile No:

Is the client aware of this referral Yes No

Any specific areas, cultural, language or religious considerations?

Reasons for referral:

Relevant background information:
Befriending Scheme Only: In view of the fact that volunteers will be unaccompanied when meeting clients and possibly entering clients' homes, please comment on any challenging or aggressive behaviour or other problems likely to be encountered in order that an assessment of risk can be made:
Indicators / triggers to client becoming unwell:
Has the client any history of aggressive or violent behaviour to self or others?
Is this client likely to become aggressive / violent?
Please specify other services used by the client e.g. clubs:

For Counselling referrals only (please indicate service required)	
One to One Counselling	
Brief Cognitive Behavioural Therapy	
Bereavement Support	
Stress Management Group	
Confidence & Assertion Group	
Relaxation Group	
Anger Management Group	

Befriending, Advocacy & Day Services referrals only
Is the client happy for the Project Manager to contact them directly: Yes No

Referring Name: Agency:	
Address: Postcode: Telephone No:	
Date:	Signature:

Copy of Care Plan enclosed Yes No

Copy of Risk Assessment enclosed Yes No

PLEASE ATTACH A COPY OF THE CURRENT CARE PLAN AND RISK PROFILE IF AVAILABLE

For Office Use only:	
Date received:	Signed by all parties: Yes / No
Name:	Signature:
Documents received: CPA Risk Profile	