# Mind and Body **Community Referral Form**

Please check that the client meets all of the criteria listed below. If all criteria are met, then please proceed with the referral and complete the form in as much detail as possible.

Once complete, please send it via post to **‘Mind and Body’, Unit H, Jubilee Way, Faversham, Kent, ME13 8GD** or securely to [**mab.kent@nhs.net**](mailto:mab.kent@nhs.net)or [**mab.kent@wearewithyou.cjsm.net**](mailto:mab.kent@wearewithyou.cjsm.net). (Please note you can only email CJSM if you have a CJSM)

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| **CRITERIA (N.B. all criteria must be met to be able to accept the referral) - Please tick:** | |
| Aged 13 – 25 years old |  |
| Lives in Kent, attends education in Kent or is registered with a Kent GP (This includes Medway, for 18-25 year olds only) |  |
| Able and willing to work within a group setting |  |
| Involved in or potentially vulnerable to self harming behaviours |  |
| Appropriate for early intervention. (i.e. not presenting with immediate risk or having complex mental health needs.) |  |
| No suicidal intent or suicide attempt within the past 3 months |  |
| They consent to this referral |  |
| They are able to attend sessions in one of the listed areas (see overleaf) |  |

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| **CLIENT’S DETAILS:** | | | |
| **Name:** |  | **Date of birth:** | / / |
| **Contact number (s):** |  | | |
| **Contact email:** |  | | |
| **Preferred methods of contact:** | Letter / Email / Text / Phone | **Can we leave an answer phone message?** | Yes / No |
| **Full address  including postcode:** | (Please specify if letter(s) should **not** be sent to the home address). | | |

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| **PREFERRED AREA FOR CLIENT TO ATTEND SESSIONS:** | | | | | |
| **N.B:** Sessions will be delivered in line with Covid-19 government guidance | | | | | |
| **Gravesend** |  | **Medway (18-25 year olds only)** |  | **Maidstone** |  |
| **Sittingbourne** |  | **Thanet** |  | **Ashford** |  |
| **Dover** |  | **Canterbury** |  | **Remote/Virtual preferred** |  |

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| **REASONS FOR REFERRAL:** |
| *Please state what the client’s difficulties are, including the frequency and duration of these.* |

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| **IDENTIFIED RISKS (please tick):** | | | |
|  | **Current** (last 2 weeks) | **Recent** (past 6 months) | **Historical** (0ver 6 months) |
| Self-harm |  |  |  |
| Harm to others |  |  |  |
| Suicidal thoughts |  |  |  |
| Suicide attempts or plans |  |  |  |
| Physical/sexual/emotional abuse |  |  |  |
| Parental mental illness |  |  |  |
| Domestic violence in the home |  |  |  |
| Parenting difficulties |  |  |  |
| Other |  |  |  |
| *For each risk identified, please provide details* | | | |

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| **PROTECTIVE FACTORS:** |
| *Please state what the client’s protective factors are. If there have been historical risks, please state what has changed or is different now.* |

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| **Has the client had involvement with any other services (including referrals)?**  **Yes No** | **Do they have any additional needs or disabilities?**  **Yes No** |
| *If yes, please specify which agencies (e.g. CYPMHS, Adult Mental Health Services, Early Help, Social Services) and whether this is current or historic involvement.* | *If yes, please specify.* |

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| **REFERRER DETAILS:** | |
| **Referrer Name:** |  |
| **Agency (If CYPMHS, please note specific pathway, crisis team or if the referral is coming from SPA):** |  |
| **Contact Number:** |  |
| **Email address:** |  |
| **Secure email address (e.g. CJSM/GCSX etc.):** |  |
| **Full address  (including postcode):** |  |
| **Date of referral:** |  |

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| **CONSENT:** | |
| Has this referral been discussed with the client? If so, what are they hoping to gain from it? |  |
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| **NEXT OF KIN DETAILS:** | | | | |
| **Name:** |  | | | |
| **Relationship to you:** |  | | | |
| **Contact number:** |  | | | |
| **Email:** |  | | | |
| **Full address including Postcode:** |  | | | |
| **Do you consent for them to be contacted?** | *In cases of emergency and in order to keep everyone safe, we may need to contact your next of kin, even if you have not given consent.*    Yes No **YYes No**  **es No** | | | |