



Portsmouth Mind COMMUNITY LINKS SERVICE

Referral Form (to be completed with your client)

For better
mental health

Completed application forms should be sent to:

The Administrator, Portsmouth Mind, Fratton Community Centre, Trafalgar Place, Portsmouth,
PO1 5JJ Telephone: 023 9282 7070 E-mail: info@portsmouthmind.org.uk

Community Links Befriending Service Please complete all 3 pages

REFERRER'S DETAILS

Name: Position: Signature:

Agency: Team Leader:

Address:

..... Telephone:

Date of Referral:

How long will you be working with referee?

Please give a name of a worker available to attend reviews/point of contact.....

CLIENT'S DETAILS

Name: Date of Birth: Sex:

Address:

.....

Telephone:

Please describe your ethnicity.

White British		White Irish	
White Other		Mixed White & Black African	
Mixed White and Asian		Mixed Other	
Black Caribbean (Black or Black British)		Black African (Black or Black British)	
Other (Black or Black British)		Indian (Asian or Asian British)	
Pakistani (Asian or Asian British)		Bangladeshi (Asian or Asian British)	
Other (Asian or Asian British)		Chinese	
Chinese (Other)			

Do you consider yourself to have a disability? Excluding Mental Health problems. If so, please specify

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FREQUENCY OF SUPPORT

Weekly Fortnightly

Sessions may be allocated on a weekly or fortnightly basis.

IMPORTANT CLIENT INFORMATION

To be completed for Community Links Befriending Service

Please be as thorough as possible when filling out this form.

This will help us to determine the level of urgency

Does the person being referred consider him/herself to be socially isolated?

What impact does social isolation have on his/her mental health?

Please describe family/social support

Please give details of weekly activities undertaken by the person being referred.
(i.e. Leisure/Recreation, Interaction, Ace of Clubs, Port of Call, Employment Works)

IMPORTANT CLIENT INFORMATION

Please be as thorough as possible when filling out this form.
This will help us to determine the level of urgency

Please detail the support required by the client?

Please indicate the aims, goals and expected outcomes?

Please give an indication of your client's physical health/mobility, listing any medical problems e.g. diabetes, epilepsy, haemophilia etc:

Please give an indication of the client's mental health difficulties e.g. panic attacks, fears, phobias, strong likes or dislikes.

Please give details of any risks associated with the client? (risk to self and others, substance misuse, environmental factors etc) Please attach a current Risk Assessment / CPA paperwork

CLIENT CONSENT & DATA PROTECTION

Portsmouth Mind will use the information recorded on this form to enable us to provide safe, suitable and effective support to you. The information will be stored securely and access will be limited to those involved in providing this support. We will not pass the information to any other person(s) or organisations without your express consent. All data is subject to the Data Protection Act 1998.

Please sign below to acknowledge acceptance of the above and to this referral being made.

Client's Signature: Date: