

**MENTAL HEALTH REFERRAL FORM**

|  |         |  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|---------|--|---------------|--------------|--|------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>Accommodation Preference</b>  | Leyburn |  | Northallerton |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>REFERRER</b>  |         | <b>INDIVIDUAL</b>  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Date Request Made:   |         | Title:   |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| By Whom:   |         | Name:  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Post:  |         | Address:   |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Agency:  |         | Postcode:  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address:   |         | Contact number:  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tel:   |         | <table border="1" style="width: 100%; height: 20px;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table> |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |         |  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| E-mail:  |         | DOB:   |               | Age:         |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Is the person aware of the referral?   |         | Yes/No   |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Type of accommodation occupied?  |         | BHA  |               | Lease        |  | Other      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |         | RDC  |               | Private Rent |  | Home Owner |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Criteria:</b><br>(Please tick all that apply)   |         | <b>Please list support required:</b>   |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Over the age of 18   |         |  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Accessing secondary mental health services   |         |  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Have low – medium support needs  |         |  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Has the potential to move on to independent living within 2 years  |         |  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Has a housing related support need   |         |  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Residing in the North Yorkshire County Council Local Authority area  |         |  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Does not pose any unreasonable risk to other individuals or property   |         |  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |         |  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Please let us know if you require this or any future communications, documents or letters in the following formats.<br>Please tick one box ✓ |         |  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Large print  |         | Braille  |               | Audio Tape   |  | CD         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Language other than English  |         | Which language.....  |               |              |  |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Mental Health Needs**

Please outline mental health needs

**Health and safety at current accommodation (please tick all that apply)**

Pets:

Rubbish:

Infestations:

Needles:

Excessive household waste:

Bottles:

Other:

**Is the individual known to other services? Yes / No**

Please list:

**Is the individual a risk to self and / or others? Yes / No**

Details:

**Does the individual have? :**

Care Plan

Yes / No

Risk Assessment

Yes / No

Are they up to date?

Yes / No

(Please include copy of most recent Care Plan and Risk Assessment)

**Failure to provide any relevant information may delay the assessment process**

**Please return to:**

Sarah Beniams

Broadacres Housing Association

FREEPOST RRBZ-TATA-BYHL

**Mental Health Service**

Broadacres House

Mount View

Standard Way

Northallerton

North Yorkshire

DL6 2YD

**Tel: 01609 767900****Request made by / received by:****Date:**