

Open Young Minds

Young people's Referral form



For office use:	Date received: <input type="text"/>	by: <input type="text"/>	ID: <input type="text"/>
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Open Young Minds Referral Form

The information you give on this form will be kept **PRIVATE** and **CONFIDENTIAL**, in accordance with Rochdale and District Mind's Confidentiality Policy.

Details of Person Referred	Do parents / carers know about this referral? Yes <input type="checkbox"/> No <input type="checkbox"/>
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First name: _____	Last name: _____
Date of birth: / /	Gender: _____
Language: _____	Do you need an interpreter? Yes <input type="checkbox"/> No <input type="checkbox"/>

PLEASE NOTE: Our services are primarily funded for residents living in the Rochdale Metropolitan Borough area (including Heywood, Middleton and Littleborough ONLY).

Address: _____	
Postcode: _____	if you <u>DON'T</u> want us to send you letters, put a cross here: <input type="checkbox"/>
Contact details	if you <u>DON'T</u> want us to leave telephone messages, put a cross here: <input type="checkbox"/>
Home tel: _____	if you <u>DON'T</u> want us to leave mobile messages, put a cross here: <input type="checkbox"/>
Work tel: _____	if you <u>DON'T</u> want us to send you e-mails, put a cross here: <input type="checkbox"/>
Mobile: _____	Can we contact you by text message? Yes <input type="checkbox"/> No <input type="checkbox"/>
Email: _____	

How would you <u>prefer</u> us to contact you?	Letter <input type="checkbox"/> Landline <input type="checkbox"/> Mobile <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/>
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Details of Referrer (Please note: We may contact your referrer to update them of the progress of your referral)

Are you referring yourself? Yes <input type="checkbox"/> please continue overleaf	No <input type="checkbox"/> please complete information below
Referrer: _____	Role: _____
Organisation: _____	
Address: _____	
Postcode: _____	
Telephone: _____	Mobile: _____
Email: _____	

Monitoring Information

We collect the following information so we can monitor how service users represent the diverse communities of Rochdale and work towards fair access in our services for all groups.

How would you describe your ethnic origin?

- | | | | |
|--------|--|--------|--|
| White: | <input type="checkbox"/> White British | Black: | <input type="checkbox"/> Black British |
| | <input type="checkbox"/> White Irish | | <input type="checkbox"/> Black African |
| | <input type="checkbox"/> White Other: | | <input type="checkbox"/> Black Caribbean |
| Asian: | <input type="checkbox"/> British Asian | | <input type="checkbox"/> Black Other: |
| | <input type="checkbox"/> Pakistani | Mixed: | <input type="checkbox"/> White and Black Caribbean |
| | <input type="checkbox"/> Bangladeshi | | <input type="checkbox"/> White and Black African |
| | <input type="checkbox"/> Kashmiri | | <input type="checkbox"/> White and Asian |
| | <input type="checkbox"/> Indian | | <input type="checkbox"/> Mixed Other |
| | <input type="checkbox"/> Asian Other: | | |
| Other: | <input type="checkbox"/> (please state): | | <input type="checkbox"/> Do not wish to state |

How would you describe your sexual orientation?

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Heterosexual | <input type="checkbox"/> Bisexual |
| <input type="checkbox"/> Lesbian | <input type="checkbox"/> Gay |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Do not wish to state |

Would you describe yourself as disabled?

- | | |
|--|---|
| <input type="checkbox"/> Yes – physical issues | <input type="checkbox"/> Yes – mental health issues |
| <input type="checkbox"/> No | <input type="checkbox"/> Do not wish to state |

How would you describe your religious beliefs?

- | | |
|------------------------------------|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Muslim |
| <input type="checkbox"/> Christian | <input type="checkbox"/> Sikh |
| <input type="checkbox"/> Buddhist | <input type="checkbox"/> Jewish |
| <input type="checkbox"/> Hindu | |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Do not wish to state |

How would you describe your education / employment status?

- | | |
|---|---|
| <input type="checkbox"/> School full-time | <input type="checkbox"/> School part-time |
| <input type="checkbox"/> College full-time | <input type="checkbox"/> Pupil referral unit / other school |
| <input type="checkbox"/> Employed full-time | <input type="checkbox"/> College part-time |
| <input type="checkbox"/> Training full-time | <input type="checkbox"/> Training part-time |
| <input type="checkbox"/> Not in education, training or employment | <input type="checkbox"/> Self-employed |
| <input type="checkbox"/> Other | <input type="checkbox"/> Do not wish to state |

Reason for the referral

Describe below the wellbeing or emotional health issues.

From our list of services which do you think you would like to access

Have you / the young person / child ever had a diagnosis, if so, what is it?

Do you agree with this diagnosis? Yes No

How long have you had these issues?

Less than 6 months 6 months – 1 year 1 – 2 years Over 2 years

Are there any physical health issues?

Are there any specific physical issues you think we should know about
e.g. disabilities, epilepsy, asthma, diabetes

Are there any other issues, we need to know about?

Any other issues you think we should know about, e.g. learning difficulties, mobility issues,
alcohol/drug dependency?

Your Current Support We will not contact these people without your permission

GP's name: _____ Telephone: _____ Permission to contact Yes / No
 GP's address: _____

School / college details if applicable

School/college name: _____
 Year group: _____ Permission to contact Yes / No

Please give details of any support workers you have, e.g. CAMHS, YOT/YOS, Counsellor, TYS, Social Worker, Community Mental Health Team, Alcohol/Drugs Work, Early Break, Mentor, Carer, Careers officer, Teacher, etc:

Role	Name	Service	Permission to contact
			Yes / No
			Yes / No

Rochdale and District Mind are part of the single point of access for young people's emotional health and wellbeing. If another service can provide alternative or other support we would like to share your information with them. **Please confirm below this is agreed.**

I agree for my information to be shared with Healthy Young Minds (formerly CAMHS)	Yes / No
I agree for my information to be shared with #THRIVE	Yes / No
I agree for my information to be shared with Link4Life (L4L)	Yes / No
I agree for my information to be shared with Early Break	Yes / No

Your support needs How can the different groups and services we offer help you?

Support needs? E.g., do you need a peer navigator to take you to specific group? Send text reminders for groups? Give you information about the group? Or stay in group with you? Please let us know how you feel a peer navigator could benefit you.




Are there any specific outcomes that need to be addressed? E.g. get bus to group, or attended group.

-
-
-

Emergency Contact Details Please give us detail of someone we can contact in an emergency

Name of person: _____ Relationship to you _____
 Address: _____
 Telephone: _____ Postcode: _____
 Mobile: _____

Thank you for taking your time to complete this form
The Stirling Children's Wellbeing Scale

	Statements	Never 	Not much of the time	Some of the time 	Quite a lot of the time	All of the time 
1	I think good things will happen in my life	1	2	3	4	5
2	I always tell the truth	1	2	3	4	5
3	I find it easy to make a choice	1	2	3	4	5
4	I can find lots of fun things to do	1	2	3	4	5
5	I feel that I am good at some things	1	2	3	4	5
6	I think lots of people care about me	1	2	3	4	5
7	I like everyone I have met	1	2	3	4	5
8	I think there are lots of things I can be proud of	1	2	3	4	5
9	I've been feeling calm	1	2	3	4	5
10	I've been in a good mood	1	2	3	4	5
11	I look forward to each new day	1	2	3	4	5
12	I've been getting on well with people	1	2	3	4	5
13	I've been happy about things	1	2	3	4	5
14	I've been feeling relaxed	1	2	3	4	5

Risk issues

Please give us detail of any risk issues

Note: If there are risk issues, we can usually still offer you our services. By telling us about these issues, you help us ensure our services are safe for yourself and others.

Do you have any history of risk to yourself or others, for example self-harm, attempted suicide, self neglect, violence to others, sexual offence, arson, violence to property, theft?

No Yes

If **Yes**, please give details, and whether or not this is a current risk. Please enclose a risk assessment, if you have one.

Signature of person being referred: _____

Date: _____

Signature of referring worker: _____

Date: _____

Signature of parent/carer: _____

Date: _____

Thank you for completing this Referral Form.

Once we receive this completed Referral Form, the Open Young Minds Coordinator will be in touch as soon as possible.

They will arrange to meet with you/parents/family members, at a time and place convenient for you, or talk over the telephone, to discuss your needs and draw up an action plan with you.

The Open Young Minds Coordinator and you will then choose a range of activities that will provide you the appropriate support, either within Rochdale & District Mind's services and/or provided by other organisations. After a short period of time, we will ask to speak to you again to find out what is working well and what else might work, we call this a review.

Please return this completed form to:

Post: **Open Young Mind Team**
The Mind Wellbeing Centre
3 – 11 Drake Street
Rochdale
OL16 1RE

Email: referrals@rochdalemind.org.uk

Fax: **0871 528 4488**