**Referral Form for The Sanctuary**

**The Sanctuary is unable to accept those who have:**

1) intoxication causing incoherence/ lack of cooperation and /or aggressive behaviour
2) self harmed at this time (rather than just thinking of self harming)

3) pose a risk of harm to others/ are behaving aggressively
3) made a current attempt to end their life or have expressed plans to imminently

|  |  |
| --- | --- |
| **Date and time of referral contact call:** |  |
| **Referral made to (site):** |  |
| **Name of referrer:** |  |
| **Role:** |  |
| **Agency/organisation:** |  |

|  |
| --- |
| **Client Details**  |

|  |  |  |  |
| --- | --- | --- | --- |
| **First name:** |  | **Surname:** |  |
| **Date of Birth:** | **DD / MM / YYYY** | **Gender:** |  |

|  |  |
| --- | --- |
| **Address** |  |
| **Contact number:**  | **Home: Mobile:**  |
| **Please delete as appropriate:**  | **Consent to contacted by letter YES / NO any further contact notes:** **Consent to be contacted by phone YES / NO****Consent for voicemails to be left YES / NO****Consent to be contacted by text YES / NO**  |

|  |  |
| --- | --- |
| **GP name & practice:** |  |

**The Sanctuary is accessed entirely voluntarily. Referrals will not be accepted without client consent.**

**Has the client given consent for this referral?**

Yes 🞏 No 🞏

***NWAS ONLY***

**Has an ambulance crew conducted a medical assessment with the client?**

(report to be submitted on arrival)

🞏 Yes 🞏 No

***GMP/BTP ONLY***

**Has the Officer identified any current RAVE risks?**

**R**esistance, **A**ggression, **V**iolence (to self or others) or risk of **E**scape.

 🞏 Yes 🞏 No \*Note: If yes, The Sanctuary service is unsuitable

**Referral Information**

**Reason for referral** (Please outline the client’s presentation, immediate issues, and reason for believing suitability of client to access The Sanctuary)

**Please highlight any identified risks:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Current** | **Historic** | **If yes, please give details:** |
| Thoughts of self harm  | 🞏 Yes 🞏 No | 🞏 Yes 🞏 No |  |
| Thoughts of suicide  | 🞏 Yes 🞏 No | 🞏 Yes 🞏 No |  |
| Risk to others  | 🞏 Yes 🞏 No | 🞏 Yes 🞏 No |  |
| Other (Please specify)  | 🞏 Yes 🞏 No | 🞏 Yes 🞏 No |  |

**Has your client ever been referred to or accessed Secondary Mental Health Services?**

[Do they have a care coordinator/ mental health support worker?]:

🞏 Yes 🞏 No 🞏 Unknown

**Is your client currently prescribed any medications for mental health problems?**

 🞏 Yes 🞏 No 🞏 Unknown

 Details:

**Does the client currently have vulnerable dependents in their care that require support?**

🞏 Yes 🞏 No

**Please outline any specific needs which we may have to take account of:**

🞏 Language 🞏Cultural 🞏 Disability/ mobility issues 🞏other (please specify)

 Details: