



Application For Community Based Services

February 2016

Please complete this form, the Information provided in this application will be treated as confidential and will not be passed to anyone outside of Richmond Fellowship without the Applicant's permission. Some of the questions may not apply to you, if this is the case, please leave the question unanswered and move on to the next question.

Once completed please return the form to
Richmond Fellowship

Old School Building, Dartford Road, March PE15 8AN Or 15-16 Church mews, Wisbech PE15 1HL

Personal Information

Name of Service that you are applying for

Address:

Title: Mr Mrs Miss Ms
 Dr Other

Gender: Male
 Female

Forename:

Home tel:

Surname:

Mobile tel:

Address:

Other tel:

Postcode:

Date of Birth:

Email:

NI number:

Ethnicity

White

Mixed

Asian or
Asian British

Black or
Black British

Chinese or
Other ethnic
group

British

White & Black
Caribbean

Indian

Caribbean

Chinese

Irish

White & Black
African

Pakistani

African

Other

Other

White & Asian

Bangladeshi

Other

Other

Other

Health Information

Approximately when did you first experience mental health problems?

Do you have any secondary problems or difficulties? (please tick all that apply)

Learning disability Physical disability

Drug or Alcohol problem Sensory Disability

Do you have any other specific needs, or health problems we should be aware of, please detail here:

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Current Situation

Can you explain what your current situation is in relation to your mental health. What is your current mental health? How does it affect you on a day to day basis? What current support do you have?

Goals

What would you like to achieve from using our services?.

Referrer Information

Referring agency:	Referrer name:
Agency type:	Referrer job title:
Address:	Work tel:
Postcode:	Mobile tel:
	Email:

Risk Assessment

Is a current risk assessment available: Yes No If YES, please include with this referral.

Are you under CPA? Yes No If YES, please include in referral.

Any other information

Is there any other information you feel we should be aware of?



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Health Professional Protection and Safety Screen

PLEASE NOTE: If a Care Programme Approach (CPA) does not exist, or is not available, this form should be completed in all cases.

Do any of the following apply? (please give additional information where you have indicated 'yes'). If unknown, please leave blank.

1. Have you spent any time in hospital due to your mental health in the last 3 months?	YES/NO
2. Has the applicant a history of drug and/or alcohol misuse in the last 5 years?	YES/NO
3. Does the applicant have any other history which might cause a risk to themselves or others (eg self injury, self neglect, violence etc)? <i>(please specify)</i>	YES/NO
4. Does the applicant have a history of offending behaviour (eg arson)?	YES/NO
5. Anything else you feel we need to be aware of?	YES/NO

Signatures

Please note the following: As part of this application you are also giving the Richmond Fellowship permission to collect, retain and process information about you, such as age, gender and ethnic origin. This information will only be used to allow the organisation to monitor compliance with the law and best practice in terms of equal opportunity and non-discrimination. You are also consenting to Richmond Fellowship contacting the referrer for further information if required.

Client: Date:

Referrer: Date: