**

**Wraparound Service Referral Form**

**(over 50’s Mental Health support)**

**PLEASE READ BEFORE COMPLETING**

**The Wraparound service CAN support:**

* **Individuals who are experiencing low level mental health difficulties.**

*e.g. low mood, anxiety, challenges with difficult life changes*

* **Individuals who will benefit from time-limited support over 6 sessions.**

*e.g. emotional and practical support, encouragement and enablement.*

* **Individuals who can engage with a goals-based approach.**

**The Wraparound service CANNOT support:**

* **Individuals with Severe and Enduring Mental Illness (SMI).**

*e.g. personality disorders, schizophrenia, bipolar, long-term depression/anxiety.*

* **Individuals who are accessing secondary care services.**

*(unless there is a clear need identified that can be addressed within low level community services alongside the secondary care intervention. This should be discussed with the team prior to referral submission. Please contact us at* [*wraparound@ageukwd.org.uk*](mailto:wraparound@ageukwd.org.uk)*).*

* **Individuals who are in crisis or present as ‘high risk’.**

**Please note: any incomplete or inappropriate forms will be returned to the referrer.**

|  |  |  |
| --- | --- | --- |
| **Date:** | | **Time:** |
| **SECTION 1 - REFERRER’S DETAILS** | | |
| **Referrer’s name:** |  | |
| **Referrer’s address/organisation:** |  | |
| **Referrer’s Tel No/email address:** |  | |
| **Relationship to referred:** |  | |
| **Brief explanation of your work with the individual you are referring:** |  | |

**SECTION 2 - CLIENT DETAILS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Mr Mrs Miss Ms Other (please state)**  **Client Name:**  **Prefers to be known as:** | | | **Date of Birth:** | |
| **Client Telephone No:** | |
| **Address:**  **Postcode:** | | | **Registered GP Practice:** | |
| **Has the client consented to referral?** | **Yes** | **No** | |  |
| *(You must gain the clients consent before submitting your referral, incomplete consent will be returned to the professional)* | | | | |
| **Please state if the client has any communication needs:**  *(e.g.. hearing/speech/sight/cognitive/language)* | | | | |
| **Please provide a description of the reason you are referring this client:**  *This should include:*   * A brief history of their mental health * Previous support accessed * Relevant medications * Current presenting issues | | | | |
| **Are there any other services supporting this client?** *(Please provide service name, nature of the support, if this has an end date or is ongoing and any key professional contact details)* | | | | |
| **Does the client consent to us sharing information with**  **these services to allow us to best support them? Yes No** | | | | |
| **What support does the client require from AgeUKWD Wraparound?**  *(Please include the clients wishes where possible)* | | | | |

**SECTION 3 - RISK ASSESSMENT**

To ensure we can support the individual you have referred, in the safest way, we ask that you carefully consider the following questions and provide as much detail as possible.

Where risks are identified, please provide details of how these are currently managed.

|  |
| --- |
| **Does the individual pose any current or historical risk to themselves?**  *(e.g. self-harm, suicidal thoughts, self-neglect, etc)* |
| **Is the individual at risk of harm from others?** *(e.g. abuse, neglect, vulnerability)* |
| **Does the individual pose any current or historical risk to others?**  *(e.g. family members, staff, members of the public)* |
| **Does the individual have any allergies or medical conditions that we need to be aware of?** |

**SECTION 4 - CONTACT DETAILS**

|  |  |
| --- | --- |
| **Contact to be made with: Client Referrer (as above) Other (give details below)** | |
| **Name:** |  |
| **Tel No:** |  |
| **Relationship to client:** |  |

**Please send completed Form to:** [**wraparound@ageukwd.org.uk**](mailto:wraparound@ageukwd.org.uk)

**-----------------------------------------------------------------------------------------------------------------------------------------------**

***This section is intended for AgeUKWD use only:***

|  |  |
| --- | --- |
| **Referral received by: *(name)*** |  |
| **Referred to: *(staff/volunteer name)*** |  |

**Age UK Wakefield District** **t:** 01977 552114

7 Bank Street **e:** admin@ageukwd.org.uk

Castleford **www.ageukwd.org.uk**

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