



North Staffs Mind Befriending/Mentoring Service Self-Referral Form

Access to our service is open and we are able to accept self-referrals and referrals from carers and relatives for befriending/mentoring support for individuals. However all *self-referrals* have to be outside CPA/Care Co-ordination arrangements.

Any queries about completion of the form should be made to the Befriending Worker at North Staffs Mind on **01782 262100**
Email: jorobinson@nsmind.org.uk

Full Name
Address
Telephone Number
Date of Birth

Where did you hear of North Staffs Mind’s Befriending /Mentoring Service?
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Why are you making a self-referral to North Staffs Mind’s Befriending /Mentoring Service?
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What areas of support do you consider our service could offer you?
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What potential interests have you identified?

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What other agencies do you currently receive support from? Please list below.

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What are the goals and outcomes you would want to achieve from a volunteer being involved with you?

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The maximum term that the Befriending Service can support clients is 6 months. How long do you anticipate our support might be needed for?

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Do you have any medical conditions (e.g. epilepsy, heart condition) or anything else we need to be aware of to ensure that we can assist you appropriately if they arise?

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General Practitioner (GP) Contact Information

GP Name

Surgery Address

Telephone Number

Do you have a Consultant Psychiatrist? YES / NO

Name

Address

Telephone Number

Do you have a Social Worker? YES / NO

Name

Social Services Address

Telephone Number

Do you have a Community Psychiatric Nurse? YES / NO

CPN Name

Based at

Telephone Number

Is there any other relevant information you would like to provide us with in support of your referral?

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Client Consent and Data Protection

North Staffs Mind will use the information recorded on this form and enclosed supporting documentation to enable us to provide suitable and effective support to the client. The information will be stored securely and access will be limited to those involved in providing this support.

We will not pass the information to any other person(s) or organisations without your express consent. All data is subject to the Data Protection Act 1988.

Please sign below to acknowledge acceptance of the above.

Client's signature:

Date:

Please return the completed Referral Form and Equal Opportunities Monitoring Form to:-

**Befriending/Mentoring Worker
North Staffs Mind
83 Marsh Street
Hanley
Stoke-on-Trent, ST1 5HN**

Please mark your envelope PRIVATE AND CONFIDENTIAL.

For Office Use only:

Date referral received

Referral accepted: YES / NO

BEFRIENDING/MENTORING SERVICE
EQUAL OPPORTUNITIES MONITORING FORM

North Staffs Mind is committed to taking positive action to fight unlawful discrimination in every aspect of its work, including the services we provide. No person attempting to access one of our services shall be denied on the grounds of mental health, gender, colour, ethnicity, religious belief, sex or sexual orientation, or disability.

All individuals referred for our Befriending/Mentoring Service are asked to complete this form. The information provided will only be used to try to make our services more inclusive for all local communities. A well managed and effective service must take into account the needs of a range of individuals.

* * *

How would you prefer to describe your ethnic origin?
(The Commission for Race Equality recommends these categories)

- | | | | |
|-----------------|--------------------------|------------|--------------------------|
| Bangladeshi | <input type="checkbox"/> | Chinese | <input type="checkbox"/> |
| Black African | <input type="checkbox"/> | Indian | <input type="checkbox"/> |
| Black Caribbean | <input type="checkbox"/> | Irish | <input type="checkbox"/> |
| Black | <input type="checkbox"/> | Pakistani | <input type="checkbox"/> |
| White | <input type="checkbox"/> | Vietnamese | <input type="checkbox"/> |

Other (please specify)

Do you consider yourself to have a disability (other than your mental health issue)? Yes/No

Gender Male/Female

Age

* * *

This form will be separated from your completed Referral Form on receipt and the information it contains will NOT be used in deciding whether or not to offer you support. The information provided will be used ONLY for monitoring purposes and will be treated as confidential.

PLEASE RETURN THIS FORM WITH THE COMPLETED REFERRAL FORM.

THANK YOU FOR YOUR ASSISTANCE

For office use only:-

Date received.....

North Staffs Mind Befriending/Mentoring Service Client Agreement

Name of Client_____

- We agree that the above named will participate in the North Staffs Mind Befriending/Mentoring Service.

- The above named agrees to be befriended/mentored by a North Staffs Mind volunteer for a minimum of 2 hours per week, the relationship will be reviewed at 6 weeks, 3 months, 6 months and 12 months for longer relationships.

- The above named agrees to work within the guidelines of the Befriending/Mentoring Service and organisational policies and procedures of North Staffs Mind.

- The above named undertakes that if they are unhappy with any aspect of the service provided by North Staffs Mind or if there are any problems they will contact the Befriending/Mentoring Worker immediately.

- All information learned in the befriending relationship is strictly confidential.

- The North Staffs Mind Befriending/Mentoring Service agrees to support the client throughout their time with the organisation.

- The above named agrees to show respect for themselves and the volunteer at all times.

Client's signature_____

Befriending/Mentoring Worker's signature_____

Date_____