



**North Staffs Mind - Befriending/Mentoring Service
Care Co-ordination Referral Form**

It is anticipated that this application form will be completed jointly between the client requiring support and the professional making the referral. We will be unable to consider referrals that are incomplete so please ensure that all the supporting documentation requested is included.

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

Details of person being referred:

Name

Address

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.....

Telephone Number

Date of Birth

Where did you hear of North Staffs Mind’s Befriending /Mentoring Service?

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Why is the client being referred to North Staffs Mind’s Befriending/ Mentoring Service?

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What areas of support do you consider our service could offer to your client?

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What interests have you identified with the client?

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Who else is involved in providing the client's package of support?

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What are the anticipated aims, goals and expected outcomes from our involvement with your client?

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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 your client appropriately if they arise?

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Is there any other relevant information in support of this referral?

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Care Co-ordinator contact information

Name
Designation
Agency and Address
.....
.....
Telephone Number
Fax Number
Email Address

Referrer Details

Name
Designation
Agency and Address
.....
.....
Telephone Number
Fax Number
Email Address

Supporting documentation enclosed:

- Care Assessment
- Risk Assessment
- Care Plan

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 and to consent to this referral being made on your behalf.

Client's signature:

Date:

Please return the completed Referral Form, Equal Opportunities Monitoring Form and supporting documentation 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_____