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| Progress of Referral (to be completed by the Office) | |
| *Date of first visit:* | |
| *Date of referral:* | |
| *Date of internal assessment:* | |
| *Start date:* | *Keyworker:* |

**REFERRAL FORM FOR PORTUGAL PRINTS**

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| ***Name:*** | | ***Date of Birth:*** |
| ***Address:*** | | |
| ***Landline:*** | ***Mobile:*** | |
| ***Email:*** | | |
| ***Borough:*** | ***NI Number:*** | |

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| **Lead Professional or GP Contact Details** | |
| ***Name:*** | |
| ***Team/Practice name:*** | |
| ***Address:*** | |
| ***Email:*** | |
| ***Telephone:*** | ***Duty Number:*** |

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| **Emergency Contact Details** | |
| ***Emergency contact:*** | |
| ***Tel Landline:*** | ***Tel Mobile:*** |

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| **Referrer Contact Details** | |
| ***Name:*** | |
| ***Team name:*** | |
| ***Address:*** | |
| ***Telephone:*** | ***Email:*** |

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| **Personal Details** | |
| ***Nationality:*** | |
| ***Gender:***  Male (including transgender men)  Female (including transgender women)  Prefer to self describe as \_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_ (non-binary, gender-fluid, agender, please specify)  Prefer not to say | |
| ***Number of dependents/children:*** | ***Are you a carer?*** |
| ***Ethnicity (please specify):***  Arab/North African  Asian  Black British African  Black British Caribbean  East European  Irish  Mixed Other  West European  White African  White British  *If Other, please specify:* | ***Religion:***  Christian  Hindu  Jewish  Muslim  No religious affiliation or belief  Prefer not to say  *If Other, please specify:* |
| ***Accommodation status:***  Care home  Hospital  Hostel  Housing Association  Independent  Living with family  Residential home  Statutory homeless  Supported accommodation  Resettlement | ***Refugee status:*** |
| ***Financial status:***  No Recourse to Public Funding  Self-Financing  Unwaged ESA  Unwaged JSA  Unwaged PIP  Waged |

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| **Mental Health Details** | |
| ***Current mental health:*** | |
| ***Number of hospital admissions in past three years:*** | ***Date of last admission:*** |
| ***Section status:***  S117  S37-41  CPA | ***Care status:***  Primary care  Secondary care |
| ***Other services currently accessed (if any):*** | |

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| **Other Information** | |
| ***Employment status:***  In education (full time)  In education (part time)  In employment (full time)  In employment (part time)  In training  Not in education, training or employment | ***Disability (please specify):***  Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Unknown |
| ***Present needs:*** | |
| ***Work history / Skills / Interests:*** | |
| ***Additional notes:*** | |

If you are self-funding, please skip this page.

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| **FUNDING: PERSONAL BUDGET** |

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| ***Framework/PO Number:***  ***Number of sessions per week:***  Cost of service is £30 per session; £60 per day.   |  | | --- | | *(To be confirmed during first meeting with PP staff)*  Please circle or highlight your days and times:  **Tuesday**  AM (10.15 - 12.30) PM (1.30 – 3.45)  **Wednesday**  AM (10.15 – 12.30) PM (1.30 - 3.45)  **Thursday**  AM (10.15 - 12.30) PM (1.30 - 3.45)  **Friday**  AM (10.15 - 12.30) PM (1.30 - 3.45)  **Agreed Start Date**: |   Please note that we require new clients to commit to a one month trial period. We will bill for the agreed number of days/sessions, even if the client does not attend. Thereafter, should clients wish to make changes to their attendance, we will require a month's notice. If no notice is given and we are unable to contact the client, we will continue to bill for 2 months before removing the client from our books. We are happy to discuss temporarily suspending your billing in the event of hospitalisation or extended leave (minimum period of a month).   |  |  | | --- | --- | | ***Client’s signature:*** | ***Date:*** | | ***CC’s signature:*** | ***Date:*** |   Please sign to confirm agreed payment. Once we have confirmed a start date, we will email you a final copy for your records. Thank you. |

If your client has a personal budget, please skip this page.

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| **FUNDING: CONFIRMATION OF INDEPENDENT FUNDING** |

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| This letter is to confirm that I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name),  agree to pay for \_\_\_ sessions per week with Portugal Prints at a cost of £30 per session/half day.   |  | | --- | | *(To be confirmed during first meeting with PP staff)*  Please circle or highlight your days and times:  **Tuesday**  AM (10.15 - 12.30) PM (1.30 – 3.45)  **Wednesday**  PM (1.30 - 3.45)  **Thursday**  AM (10.15 - 12.30) PM (1.30 - 3.45)  **Friday**  AM (10.15 - 12.30) PM (1.30 - 3.45)  **Agreed Start Date**: |   Invoices are distributed monthly. We ask new clients to commit to a one month trial period as it can take some time to adjust to the journey and new environment.  Please note that you will be invoiced at the end of every month for the attendance that has been agreed, even if you do not attend. This is because we are holding a space for you. We do make exceptions for holidays that we are notified of in advance. For any unscheduled missed days, we welcome you to make up the sessions missed on a different day during the same week - this is subject to space availability and needs to be discussed with staff beforehand.  Should you wish to make changes to your attendance or to stop attending to Portugal Prints, please speak to your keyworker. We require a month’s written notice to stop all invoicing. If no notice is given and we are unable to contact the client, we will continue to bill for 2 months before removing the client from our books.  Please sign to acknowledge that you understand the terms of payment:   |  |  | | --- | --- | | ***Client’s signature:*** | ***Date:*** |   Your invoice can be distributed via Portugal Prints, or sent to you directly. Please let us know your preference: **via Portugal Prints** | **Mailed directly**  **Mailing Address:**  Please save a copy for your own records (staff can make a photocopy for you). |

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| **Documents to enclose** |

***Please ensure the following documents are enclosed with the completed referral form:***

*Most recent Risk Assessment for the client*

*Most recent care plan OR discharge summary for the client*

**Please send all documents and completed referral form to:**

Email: pp@bwwmind.org.uk

**Or post to:**

Portugal Prints,

**Studio 125**,

Great Western Studios,

65 Alfred Road,

London,

W2 5EU

**Please call us if you have any queries:** 020 7267 7809