Social Prescribing Link Worker Referral Form

CLIENT DETAILS:	
Your Name:	**Referral Date:**

Address:

Contact number(s):

Email Address:

Date of Birth:

NHS Number:

General Practice:

Ethnicity: (✓tick one)

White-British | White-Irish | White-Other
Asian or Asian British :
Indian | Pakistani | Bangladeshi | Other
Mixed-White & Asian
Black or Black British-
Caribbean | African | Other
Mixed-White & Black: Caribbean | African
Chinese or other ethnic group
Gypsy, Romany, Traveller | Declined

Disability: (✓tick any that apply to you)

Do you consider yourself disabled? YES | NO

Mental Health
Sight Impairment
Hearing Impairment
Speech difficulty
Autistic Spectrum
Learning Difficult
Dementia
Mobility
Progressive Illness
Declined

Please let us know about any long term health conditions: (✓tick any that apply to you)

Health Condition:	**Please Tick**		**Please Tick**
Stroke		Motor Neurone Disease	
Diabetes		Cancer	
Memory Problems		Heart Disease	
Parkinson's		Auto Immune Disease	
Multiple Sclerosis		M.E.	
Arthritis		Muscular Dystrophy	
COPD			

Other *Please give details:*

Your Next of Kin:

Their Contact Number(s):

Your Current situation and reason(s) for referral:
(please include any relevant health conditions and areas of concern)

Have you used the Arc Social Prescribing service before? Yes/No

If yes, how long ago?

If you are re-accessing this service please say why you are unable to resolve the issues without the support?

Where did you hear about our service?

Do you have a care package in place? Yes / No

Do you have a mental Health worker? Yes / No

Are you under the care of Prevention Matters? Yes / No

Are you involved with any other professionals? *(E.g. social worker/ Occupational Health Service/ Mental Health care package in place. (include name and telephone number)*

Service(s):

Contact Name(s):

Contact Number(s)*:*

Risk Indicators Summary
(Please note this referral can not be processed if this section has not been completed).
This information is required to allow support staff to prepare for their visits.
Do you have any history or evidence of the following?
Please mark against ALL indicators.

	Yes	No	Don't Know		Yes	No	Don't Know
Aggression				Historical Substance / Alcohol use			
Arson				Sex Offences			
Domestic Abuse				Self Harm			
Current Substance / Alcohol use				Other (please specify)			

Is there anything else that you feel we should know about you or your circumstances in terms of risk? (e.g. pets)

Please give details:

If you are making this referral on behalf of someone else please provide your contact details:
Name:

Organisation/Team:

Relationship to the person referred:

Contact details:
Phone number:

Email:

The person you are referring should be aware of and in agreement with this referral being submitted. Is the person you are referring aware of the referral and do they give their permission? Yes / No

Please note you will receive a telephone call from the Arc Social Prescribing Team asking you for more information in relation to this referral and about any known safety concerns.

We need the information in this referral form to see if and how we may be able to help you. This information will be confidential to the Arc Primary Care Network employees & your GP. The information will only be accessed and processed by authorised individuals who have received training in handling and managing such data. It will be used only for the purposes of assessing if we can provide you with support. To do this we may need to contact the people mentioned in this referral form to gain more information. We need your consent to do this. We understand that some of the information you give us may be sensitive. If we don't have this information we may not be able to support you in the best way possible. However, **it is your choice whether you provide such information.**

The information you give may be held on both manual and electronic systems and you are welcome to update and request to change/remove your information at any time. By completing this form, you will be confirming that you give your consent for the Arc PCN to hold and process your data in line with the procedures set out above. You can at any time view our full **privacy notice** for Service Users on our website by following this link: www.arcbuckspcn.org or ask us for a paper copy.

Agency / Authority / Individual	**Consent given (✓tick)**	**Consent not given (✓tick)**
Social Worker/Care Manager		
Community/Adult Mental Health Team		
Psychiatrist/Community Psychiatric Nurse		
Youth Offending Team/Probation		
Police		
Housing Associations		
Benefits Agency		
School/College/University		

I give my consent to contact the agencies/ authorities and individuals as indicated above:

Print Name:

Signature:

Date:

Please email this referral to the one of the following addresses if registered at the one of the practices listed below:

Beaconsfield.accessteam@nhs.net
Bourne End and Wooburn Green
Millbarn Medical Centre
Simpson Centre and Penn Surgery

Marlow.accessteam@nhs.net
Marlow Medical Group
Cherrymead Surgery
Highfield Surgery