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| **A screenshot of a video game  Description automatically generated with medium confidence Self-Referral Form****Information sharing: Please complete this form to the best of your ability and in your own words, including as much information as possible. Any information provided in this form will remain confidential and will be treated in accordance with GDPR legislation.****Basic Premise of service offer: Support and advocacy service is on offer for black residents of Lambeth (18-65) with mental health conditions both on a one-to-one basis (with an assigned worker) and group basis (through drop-in sessions).****Our service workers are trained to provide culturally appropriate support that is meaningful to the needs of clients and address the racialised or discriminative factors that impact well-being outcomes for black service users.**  |
|  |
| **Date:** |  |
| **Full Name:** |  |
| **Age (at time of registration):** |  | **Date of Birth:** |  |
| **Gender:** |  |
| **Pronouns:**  |  |
| **Telephone/ Mobile Number:** |  |
| **Email:** |  |
| **Residential Address:** |  |
| **Is someone supporting you to fill out this form?**  |  |
| **Do you have a carer?**  |  |
| **Any dependents?**  |  |
| **GP Contact Information** |  |
| **Contact information for any other Support Staff**  |  |
| **Are you happy for us to liaise with any of these staff?**  |  |
| **Ethnicity:** | **Black Mixed / Multiple ethnic groups**African Black Caribbean & White/ Caribbean Black African & White Any other Black background Black Caribbean & Asian Black African & Asian  Any other Mixed background |
| **Cultural Background / Nationality/ National origin:** |  |
| **Religion / Faith/ Spiritual belief:** |  |
| **Accessibility Needs:** |  |
| **Interpreter or sign language required?**  | YES / NO | Language(s) |  |
| **Current life situation as you would describe it**  |  |
| **Physical Health Needs**  | State any conditions and how these affect your day to day activities, quality of life  |
| **Mental Health Needs (conditions, diagnoses, etc.)** | State any conditions and how these affect your mood, behaviour, activities, quality of life |
| **Any medications****or supplements taken for your physical or mental health needs** | Name of medication/ supplement, amount taken, frequency, prescribed or voluntary, duration of use so far  |
| **Feelings about any prescribed medication**  |  |
| **Are you having any issues accessing services for your physical or mental health needs? Why?** |  |
| **What do you hope CAPSA can do to help?** |  |
| **Things you would like to work on:**  |  |
| **Strengths / Goals / Interests** |   |
|  | **SAFEGUARDING HISTORY: Please indicate any safeguarding issues based on received information, past history and your knowledge.**  |
| **Risk to Self:** |  |
| **Risk from/to Others:** |  |
| **Any known triggers we should be aware of?** | E.g. Behavioural (from others), environmental (types of spaces), sensory stimuli (e.g. smells, sounds, colours etc.)  |
| **Referral Source:**  | Self: GP: IAPT:  Ward Staff: Living Well Clinic:  **Other:**  |
| **Referrer Details :** | Name: Phone/Mobile Number: Email: Organisation:  |
| **Anything you else would like us to know:** |  |