**Mental Health Crisis Breathing Space Referral Form**

Please ensure that information supplied in this form is accurate and relevant as it will help with the completion of the Mental Health Crisis Breathing Space evidence form. The individual’s personal information will be used by a debt advice provider to process an application for a Mental Health Crisis Breathing Space

Please return this completed form to the AMHP Hub mailbox

**AMHPTeam@worcestershire.gov.uk**

Are you referring yourself? Yes ☐ No ☐

If yes please complete parts of the form marked with an asterisk (\*)

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| **\*Section 1: Information about the individual** | | | | | | | | | | | | | | |
| Surname | |  | | | | | | | | | Title | |  | |
| First name (s) | |  | | | | | | | | | | | | |
| Any Alternative Name | |  | | | | | | | | | | | | |
| Date of Birth | |  | | | | | | | Gender | | | |  | |
| NHS Number: | | | | |  | | | | | | | | | |
| LAS Number: | | | | |  | | | | | | | | | |
| Ethnic Origin | | |  | | | | | | | Religion | | | |  |
| First language | | |  | | | | | | | | | | | |
| Interpreter required? | | | | | |  | | | | | | | | |
| Home Address:  Post Code:  Telephone number/s: | | | | | | | | Any other relevant addresses (e.g. respite place or hospital):  Postcode: | | | | | | |
| GP Name: | | | |  | | | | | | | | | | |
| GP Surgery and  Address: | | | | Post Code: | | | | | | | | | | |
| Telephone No. | | | |  | | | | | | | | | | |
| **Next of Kin, Nearest Relative or Significant Other Details** | | | | | | | | | | | | | | |
| Name | | | | | | |  | | | | | | | |
| Home Address | | | | | | |  | | | | | | | |
| Post Code |  | | | | | | Telephone number(s) | | | | |  | | |
| Relationship to referred person | | | | | | |  | | | | | | | |

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| **1b: Referral form completed by:** | | | | | | | |
| Name: |  | | | Date: | |  | |
| Role: |  | | | Email address: | |  | |
| Contact number: |  | | | Service/ team: | |  | |
| Are you the allocated Mental Health Practitioner: | | | Yes: ☐ No:☐ | | | | |
| If you are not the care Mental Health Practitioner please record details of the nominated point of contact below: | | | | | | | |
| Name: | |  | | | Role: | |  |
| Profession (e.g. mental health nurse or Social Worker) | |  | | | Email address: | |  |

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| **Section 2: Brief reasons for referral** | |
| Has the person named in section 1: | Been detained in hospital for assessment or treatment (including under part 3 of the Mental Health Act 1983) ☐  Been removed to a place of safety by a police constable ☐  Receiving any other crisis, emergency or acute care or treatment in hospital or in the community from a specialist mental health service. This can include services offered by community mental health services and crisis houses ☐  *Nb: A ‘specialist mental health service’ means a mental health service provided by a crisis home treatment team, a liaison mental health team, a community mental health team or any other specialist mental health crisis service* |
| \*Please state the reasons why has the person named in section 1 has been referred for a Mental Health Crisis Breathing Space? | |
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| **Section 3: The person needs to consent to information being shared with Worcestershire County Council and organisations in the mental health crisis breathing space scheme.** | | | | |
| Does the person named in section 1 have the mental capacity to consent to their information being shared for the purpose of starting a mental health crisis breathing space? | | Yes: ☐ No: ☐ | | |
| If the person named in section 1 has capacity, have they consented to their personal information being shared for the purpose of starting a mental health crisis breathing space? | | Yes: ☐ No: ☐ | | |
| If they lack capacity has consent been sought from someone the individual has previously indicated can make decisions on their behalf (e.g. a person with Lasting Power of Attorney under the Mental Capacity Act, a deputy appointed by the Court of Protection, or an appointee), if that is appropriate? | | Yes/No/n/a | | |
| Details of person with Lasting Power of Attorney under the Mental Capacity Act, a deputy appointed by the Court of Protection, or an appointee), | | LPA ☐ Deputy ☐ Appointee ☐  Name:  Contact Details: | | |
| Or, has a decision been made to refer them and for their personal information being shared for the purpose of starting a Mental Health Crisis Breathing Space in their best interests? | | Yes:☐ No: ☐ N/A☐ | | |
| If a decision has been made in their best interests what are the grounds (for example to protect them from serious physical or psychological harm)? | | | | |
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| Please can you supply a copy of the mental capacity assessment to support the referral. If you are not able to supply a copy of this assessment then please state the reasons why below. | | | Yes: ☐ No: ☐ | |
|  | | | | |
| The person named in section 1 has been supplied with a copy of the  privacy statement: | | | | Yes: ☐ No: ☐ |
| \*For persons who have capacity: | | | | |
| I agree to be referred to an Approved Mental Health Professional who will consider referring me to the Mental Health Crisis Breathing Space scheme if my needs meet the criteria. | Name: | | | |
| Signature: | | | |
| Date: | | | |

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| **\*Section 4: Additional information**  *If you can provide any information about the debts the person owes, or their income, then this will help to quickly stop them from being chased by their creditors about their debts. Perhaps they have mentioned particular debts or bills that are causing them anxiety, or they recently lost their source of income and are struggling to cope.*  *You do not have to do this for the MHCBS to start, but it will help if you do.* |
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| **Signature of person completing this form *(Accepted as signed when sent electronically****)* |
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