|  |  |
| --- | --- |
| **SERVICE USER NAME** |  |
| **DATE OF BIRTH** |  |
| **NAME OF CURRENT SERVICE/WARD** |  |
| **DIAGNOSIS /****DIAGNOSES** |  |
| **MHA**Please specify date and section type (if any) |  |
| **Forensic History and Index offences** (please state) |  |
| **Under which section will the SU be discharged** |  |
| **Professionals Involved** |  |
| **Family/Friends/Next of Kin details** |  |
| **If AWOL PROFESSIONALS TEAM TO CONTACT** |  |
| **DISCHARGE PATHWAY** |  |
| **BOROUGH OF REFERRAL** |  |
| **RECOVERY TEAM** If connected to a team |  |
| **APPOINTEESHIP** details if relevant |  |
| **REASON FOR REFERRAL** |  |
| **DATE OF REFERRAL** |  |
| **NAME OF REFERRER**  |  |
| **REFERRER ORGANISATION** |  |
| **DOCUMENTS ATTACHED WITH FORM** (please tick and attach date of document – this includes ID documents and proof of benefits or benefits applications  | **CARE PLAN** | **RISK OVERVIEW** | **DISCHARGE SUMMARY** | **ID Documents**  | **Proof benefits**  |
|  |  |  |  |  |
| **ANY OTHER RELEVANT INFORMATION** |  |
| **NHS NUMBER** |  |
| **Does the Service User have proof of ID? Confirm which ID has been seen – passport / birth certificate**  |  |
| **NI NUMBER** |  |
| **RECEIPT OF BENEFITS**if so which benefits? Please state. |  |
| **HOUSING BENEFIT APPLICATION NO** |  |
| **CURRENT ADDRESS OR MOST RECENT ADDRESS** |  |

**Eligibility Criteria:**

* **Aged 18-65**
* **Background information if available e.g. CPA Report, OT Report, etc.**
* **Service User is prepared to engage with support services provided**

**Making a referral:**

**We accept individuals with a primary diagnosis of severe and enduring mental illness, with offending history, who may have complex needs such as Schizophrenia, Personality Disorder, Mild Learning Disability and who may have been treated in a secure psychiatric hospital, residential care homes, prison service and have a history of challenging behaviours.**

**Send completed form to:** **admin@diverseservices.co.uk**