

Progress of Referral (to be completed by the Office)	
<i>Date of first visit:</i>	
<i>Date of referral:</i>	
<i>Date of internal assessment:</i>	
<i>Start date:</i>	<i>Keyworker:</i>

REFERRAL FORM FOR PORTUGAL PRINTS

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

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

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

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

Personal Details	
Nationality:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Different from that assigned from birth <input type="checkbox"/> Prefer not to say	Sexuality: <input type="checkbox"/> Bisexual <input type="checkbox"/> Heterosexual <input type="checkbox"/> Lesbian <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to say
Number of dependents/children:	Are you a carer?
Ethnicity (please specify): <input type="checkbox"/> Arab/North African <input type="checkbox"/> Asian <input type="checkbox"/> Black British African <input type="checkbox"/> Black British Caribbean <input type="checkbox"/> East European <input type="checkbox"/> Irish <input type="checkbox"/> Mixed Other <input type="checkbox"/> West European <input type="checkbox"/> White African <input type="checkbox"/> White British <i>If Other, please specify:</i>	Religion: <input type="checkbox"/> Christian <input type="checkbox"/> Hindu <input type="checkbox"/> Jewish <input type="checkbox"/> Muslim <input type="checkbox"/> No religious affiliation or belief <input type="checkbox"/> Prefer not to say <i>If Other, please specify:</i>
Accommodation status: <input type="checkbox"/> Care home <input type="checkbox"/> Hospital <input type="checkbox"/> Hostel <input type="checkbox"/> Housing Association <input type="checkbox"/> Independent <input type="checkbox"/> Living with family <input type="checkbox"/> Residential home <input type="checkbox"/> Statutory homeless <input type="checkbox"/> Supported accommodation <input type="checkbox"/> Resettlement	Refugee status: Financial status: <input type="checkbox"/> No Recourse to Public Funding <input type="checkbox"/> Self-Financing <input type="checkbox"/> Unwaged ESA <input type="checkbox"/> Unwaged JSA <input type="checkbox"/> Unwaged PIP <input type="checkbox"/> Waged

Mental Health Details
Current mental health:

Number of hospital admissions in past three years:	Date of last admission:
Section status: <input type="checkbox"/> S117 <input type="checkbox"/> S37-41 <input type="checkbox"/> CPA	Care status: <input type="checkbox"/> Primary care <input type="checkbox"/> Secondary care
Other services currently accessed (if any):	

Other Information	
Employment status: <input type="checkbox"/> In education (full time) <input type="checkbox"/> In education (part time) <input type="checkbox"/> In employment (full time) <input type="checkbox"/> In employment (part time) <input type="checkbox"/> In training <input type="checkbox"/> Not in education, training or employment	Disability (please specify): <input type="checkbox"/> Yes: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
Present needs:	
Work history / Skills / Interests:	
Additional notes:	

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

FUNDING: PERSONAL BUDGET

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 (10-12.15) PM (1.15-3.30)

Wednesday

AM (10-12.15) PM (1.15-3.30)

Thursday

AM (10-12.15) PM (1.15-3.30)

Friday

AM (10-12.15) PM (1.15-3.30) Evening (3.30-5.30)

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.

FUNDING: CONFIRMATION OF INDEPENDENT FUNDING

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 (10-12.15) PM (1.15-3.30)

Wednesday

AM (10-12.15) PM (1.15-3.30)

Thursday

AM (10-12.15) PM (1.15-3.30)

Friday

AM (10-12.15) PM (1.15-3.30) Evening (3.30-5.30)

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:

<i>Client's signature:</i>	<i>Date:</i>
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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).

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, Arlington House
220 Arlington Road,
London NW1 7HE

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