Referral Form

Through The Gate

Your opportunity to become an apprentice volunteer in Lindengate's gardens with peer support

Date received: _____ **Staff initials:** _____

This form needs to be completed together with your relevant care professional. Please download this form before editing fields.

Personal details:

Title:	Gender: ☐ Male ☐ Female ☐ Other
First name:	If other please specify:
Preferred name:	Age:
Surname:	Date of Birth:
Address:	Home tel:
	Mobile:
Postcode :	Email:
Please tick the activity areas at Lindengate that you are interested in: ☐ **Gardening** ☐ **Nature Conservation**	

How do you hope to improve your wellbeing at Lindengate? Please tick all that apply:

To take notice of nature		To give to others		To be more active	
To learn new skills		To connect with people			

What are your longer term aim(s)? Please tick all that apply:

Volunteering at Lindengate		Volunteering at another organisation	
Paid employment		Other (please give details)	

How do you spend your time now?

Which days would you would prefer to attend? (tick all that apply)

AM	PM	
☐	☐	Monday
☐	☐	Tuesday
☐	☐	Wednesday
☐	☐	Thursday
☐	☐	Friday
☐	☐	Saturday

Where did you hear about Lindengate?

Through the Gate is aimed at helping people with low to moderate mental health needs learn new skills and gain work experience. How would you describe your current mental health needs? Please tell us about your diagnosis if applicable:

Please let us know of any medical conditions, epilepsy, allergies, mobility, sight, hearing, substance misuse issues or anything else you think may be relevant which could affect your ability to do physical activities or work in a group, so we may ensure your safety and wellbeing. Please tell us about any other specific support you require:

See page 7 for Epilepsy Personal Care form if required.

If we need to contact your health professional, care coordinator, social worker or GP to obtain any further information that we may need to assess your level of support needs, do you give consent for this contact and for us to securely hold this information?

☐ **I consent** ☐ **I do not consent**

Your signature: ..…… Date: ……

Please provide details of any health professional, care coordinator, social worker and/or GP involved in your care:

Name:	Address:
Job title:	
Organisation or Practice:	
Work tel:	Postcode:
Mobile no:	Email:

Name:	Address:
Job title:	
Organisation or Practice:	
Work tel:	Postcode:
Mobile no:	Email:

Do you have a current Care Plan and Risk Assessment? ☐ **Yes** ☐ **No**

If you have a current occupational care plan and / or a current risk assessment this must be included with this referral.

☐ Do you currently need support for self-harm or suicidal behaviour (or have you ever needed support with this in the past)?

☐ Do you currently need support for violent or abusive behaviour towards others or things around you (or have you ever needed support with this in the past)?

☐ Do you have any criminal convictions?

If you have answered 'Yes' to any of these questions, please provide details in the box below so that we may ensure your safety and wellbeing:

Emergency Contacts:

In the event of an accident or incident please tell us who we should contact:

First contact name:	Address:
Relationship to you:	
Home tel:	

Mobile no:	
Email:	Postcode:

Second contact name:	Address:
Relationship to you:	
Home tel:	
Mobile no:	
Email:	Postcode:

Video / Photograph Consent

It is our policy that where we are planning to use an image (photograph or video) for materials in the public domain, consent must be obtained by the appropriate person. Image consent can be changed or withdrawn at any time by notifying a member of staff. However, we cannot withdraw still or moving image(s) already published on publicity material.

Please tick the boxes below to indicate your consent:

- Anonymous images where face cannot be seen or is obscured? ☐ **Yes** ☐ **No**
- Identifiable images of face? ☐ **Yes** ☐ **No**
- Video interview face-to-face? ☐ **Yes** ☐ **No**

Keeping in touch in accordance to Data Protection (GDPR)

All information provided on the referral form and in any further communications with Lindengate will be treated as confidential and will not be disclosed to any third party outside of Lindengate without your consent**.** If we are under a duty to disclose or share your data in order to comply with any legal obligation e.g. safeguarding children or vulnerable adults, acts of terrorism or money laundering we are obliged to cooperate.

From time to time Lindengate may need to contact you (for example, if there was to be closure due to weather etc.) If you agree to us contacting, you for this purpose please tick to indicate that you consent:

☐ **I consent** ☐ **I do not consent**

Your signature: ...…….…… Date: ……

Referring care professional's details

Name:	Address:
Job Title:	
Organisation:	
Contact no:	
Email:	Postcode:

Referrer's signature: …… Date: …..…….

How would you describe your ethnic origin? The following categories are recommended by the Commission of Racial Equality.

A **White**

☐ British

☐ Irish

Any other white background please write Here:

_____

B **Mixed**

☐ White and Black Caribbean

☐ White and Black African

☐ White and Asian

Any other mixed background please write Here:

_____

C **Asian or Asian British**

☐ Indian

☐ Pakistani

☐ Bangladeshi

Any other Asian background please write Here:

_____

D **Black or Black British**

☐ Caribbean

☐ African

Any other Black background please write Here:

_____

E **Chinese or other ethnic group**

☐ Chinese

Any other ethnic background please write Here:

_____

Please return to Lindengate, The Old Allotment site, Wendover Rd, Aylesbury HP22 6BD or email: referrals@lindengate.org.uk or fax: 01296 695402

Epilepsy Personal Care Record **Date:**

Please complete if appropriate

Name	
Type and description of seizure	
Normal seizure length	
Frequency of seizures	
Date of last seizure	
Known triggers	
Normal recovery time	
Prescribed medication (name and time taken)	

Medical alert card/bracelet	
Any history of status epilepticus	
Any emergency medication to be administered	