For Office Use Only
Date Received:
Induction Date:

Membership Referral Form

Date of Application: / /

Which borough has funding responsibility? RBKC ☐ Westminster[1] ☐

Applicant's Details

To be completed by the referrer

Name:

Address 1:
Address 2:
City:
Postcode:

Gender:
Date of Birth: / /

Work Tel:

Mobile Tel:

Email:

Referrer's Details

To be completed by the referrer

Name:

Agency:

Address 1:
Address 2:
City:
Postcode:

Work Tel:

Mobile Tel:

Email:

Relationship with Applicant:

The Referral Process and Your Data

Information

We need to know and store some personal information about the person referring and the person being referred in order to provide a good and safe service. If you feel unable to provide any of the information in this form please let us know and we will do our best to provide support with the information you are happy to give us. You can see our Privacy Notice at any time and this tells you how we store and use your information. Once we have received your completed form we will invite you both for an induction or with the main support worker or carer if that works better. There is the option to have separate conversations if we cannot get a date that works for everyone. At the meeting we will provide a tour or SMART and make some decision about what the person attending would like to get out of SMART. Following the meeting the new member receives a Handbook, and welcome letter with the start dates of their new projects and of their first member review (around 6 weeks after the start date)

[1] *Please note that client/patient's from Westminster must be referred by their CMHT.*

Other Contacts

To be completed by the referrer

Please list all other members of the applicant's care team.

GP/Doctor:

Name:

Surgery:

Address 1:
Address 2:
City:
Postcode:

Tel:
Mob:

Email:

Social/key worker: *Please tick here if the applicant does not have a Social/Key worker:* ☐

Name:

Agency:

Address 1:
Address 2:
City:
Postcode:

Tel:
Mob:

Email:

CPN: *Please tick here if the applicant does not have a CPN:* ☐

Name:

Agency:

Address 1:
Address 2:
City:
Postcode:

Tel:
Mob:

Email:

Other: *Please specify:*

Name:

Agency:

Address 1:
Address 2:
City:
Postcode:

Tel:
Mob:

Email:

About your Client/Patient

To be completed by the referrer

1. What is your client/patient's mental illness (primary diagnosis)?

2. Please provide any reportable symptoms of the new member becoming unwell.

3. What are your reasons for referring your client/patient to SMART?

4. Is the applicant subject to the Care Programme Approach? Yes ☐ No ☐
   If yes, please enclose a copy of the most recent CPA

5. Is the applicant eligible for Care Management? Yes ☐ No ☐
   If yes, please enclose a recent Social Services needs assessment

6. Has a Risk Assessment been carried out in the past 12 months? Yes ☐ No ☐
   If yes, please enclose a copy of the risk assessment
   If no, please enclose the most recent risk assessment or a doctor's letter

Please note that we will be unable to accept a new member without a risk assessment or a doctor's letter.

For GP referrals only:
If you are not able to provide us with recent clinical risk assessment and care plan, please complete questions 1, 2 and 3 above and we would be grateful if you could sign this disclaimer:

My client is not eligible for secondary mental health services and attends the GP practice to receive support for their mental health difficulties. At the time of this referral, there are no known risks around my patient engaging in SMART's activities.

Name: _____ Signed: _____

Date: _____

Monitoring Information

To be completed by the applicant

The following information is for statistical purposes only. The information has no effect on an individual being offered work or training at SMART, but is required by The Royal Borough of Kensington and Chelsea to monitor the service we provide.

Which area do you live in? *(please tick one)*

RBKC – North:	☐	RBKC – Central:	☐
RBKC – South:	☐	Other (Please specify):	_____

What do you consider to be your ethnic origin? *(please tick one)*

British	☐	Pakistani	☐
Irish	☐	Bangladeshi	☐
Other White	☐	Any other Asian background	☐
White/Black Caribbean	☐	Caribbean	☐
White/Black African	☐	African	☐
White/Asian	☐	Any other Black background	☐
Any other mixed group	☐	Chinese	☐
Indian	☐	Not stated/Refused to answer	☐

Other (Please specify): _____

You and SMART

To be completed by the applicant

These questions are to help us understand how we can assist you in your recovery. We will speak in more detail in your induction meeting.

What are your main reasons for wanting to be referred to SMART?

Are you planning to return to employment at some stage? Yes ☐ No ☐
If Yes, what type of employment are you most interested in?

Are you interested in doing some sort of training or study? Yes ☐ No ☐
If Yes, what area of training or study are you most interested in?

Do you have any other conditions that we should be aware of (e.g. diabetes, epilepsy)?

Your contract with SMART

To be completed by the applicant

I agree that SMART may store my information securely (you can ask us to delete you information at any time). I agree that SMART may have access to the information requested above and future versions of the information such as Risk Assessments and CPAs, in order that it can provide a safe and effective service to its members.

I also agree that SMART may copy my Care Team/Referrer in on any correspondence to me and that my Care Team/Referrer may be contacted regularly to keep updated on my attendance and engagement at SMART.

Name: _____ Signed: _____

Date: _____

Important Information

To be completed by the referrer

We are contracted by RBKC to provide day services and a programme of evening and weekend activities. We are data protection registered.

If you feel unable to share the information we have requested then please let us know why and we will do what we can to facilitate the referral of your client. Alternatively, you may wish to seek clarification about the data protection issues you face with someone on the mental health commissioning team at RBKC /Westminster.

Unfortunately, until we have reached an explicit agreement we will be unable to accept your client as a member of SMART.

I have fully completed all sections of the referral form		Yes ☐
I have enclosed a full risk assessment or doctor's letter		Yes ☐
I have enclosed a copy of my client/patient's CPA	N/A ☐	Yes ☐

Please ensure all the boxes above are ticked before signing and submitting the form.

Name: _____ Signed: _____

Date: _____

Please return to:

SMART, The Basement, 15 Gertrude Street, London, SW10 0JN or contact us on tel: 020 7376 4668; fax: 020 7376 7892; email: referrals@smartlondon.org.uk

For Office Use:

Database	
Letters Sent	
Members File	
Paper file	
Email staff	

Project	Start date	Time	Comments

Member Review:

Funded by the Royal Borough of Kensington & Chelsea