Self-Referral Form

Please first download this form before editing fields.
Data entered within an internet browser may not be saved!

Form to be completed by the person referring themselves and sent to the address on back page.

Please note: We reserve the right to withdraw your offer of a place after a trial period of 4 weeks.

All information provided will be kept strictly confidential and not shared outside of Lindengate staff without your written permission.

Date of referral:

Your details:

Male Female

Full name:

Date of birth:

Address:

Home Number:

Mobile Number:

Email Address:

Preferred means of contact?

Home Phone Mobile Email

Please indicate which days you would prefer to attend (tick all that apply):

	AM	PM
Monday		
Tuesday		
Wednesday		
Thursday		

Where did you hear about Lindengate ?

What is your reason for seeking a placement with Lindengate?

How would you describe your physical health?

How would you describe your current mental health?

If you have a diagnosis, please give details

What other Services are currently helping you with your physical and/or mental health ?

Please give the name(s) and address(es) of those services (if applicable)

Do you need any help with communication? If yes, please give details.

Are you currently taking any medications? If so, what?

What do you do to keep yourself well?

Is there any other information that you feel we should know?

Please list any known allergies, including food allergies that we should be aware of:

(If you have answered yes to any of these questions, then you will not necessarily be excluded from attending but the information will help Lindengate to work with you more effectively)

Do you have a history of self-harm?	Yes	No
Do you have a history of suicidal behaviour?	Yes	No
Do you have a history of violence towards others?	Yes	No
Do you have any criminal convictions?	Yes	No
Do you have a history of alcohol misuse?	Yes	No
Do you have a history of drug misuse?	Yes	No

If you have answered yes to any of the above questions, please give details:

Have you been admitted to any type of hospital within the last 5 years? Yes No

If you have answered yes, please provide dates, reasons and names of hospital(s) ...

Emergency Contacts:
In the event of an incident on site who should we contact (family member, mental health, worker, friend)?

First contact name:

Relationship to you:

Home number:

Mobile number:

Address:

Second contact name:

Relationship to you:

Home number:

Mobile number:

Address:

GP contact:

Dr

Surgery Address:

Phone no:

Mobile:

If we need to contact your GP or any other medical professional are you happy to give consent for this?

Yes ○ No ○

Signed:

Date:

Initial Visit Details (to be completed by Lindengate staff)

Date

Time

Please return your completed form by email to: referrals@lindengate.org.uk

Or by post to: **Service User Manager**
Lindengate
World's End Garden Centre (Wyevale), Old Allotment Site
Aylesbury Road
Wendover
Buckinghamshire. HP22 6BD

Phone: 01296 622443

Please mark as "Private and Confidential"