Referral Type	Mental Health Professional

Office Use Only:	Date Form Received:	Start Date:	Funding:

WELLBEING PATHWAYS REFERRAL FORM

Wellbeing Pathways is a weekly programme for those with low to moderate wellbeing needs, focussing on nature-based activities in small groups of up to 6.

- **Section 1, 2 & 4** are to be completed by either the individual or together with the referrer
- **Section 3** should be completed with/by the referring professional.

Wellbeing Pathways

SECTION 1: CONTACT DETAILS

Title:	Gender: ☐ Male ☐ Female Prefer to self-describe as _____ ☐ Prefer not to say
First name:	
Preferred name:	Address:
Surname:	
Date of Birth:	Postcode:
Phone number (either landline or mobile):	Email:

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

Emergency Contact 1:	**Emergency Contact 2:**
Contact name:	Contact name:
Relationship to you:	Relationship to you:
Phone number:	Phone number:

SECTION 2: WELLBEING

Where did you hear about Lindengate?

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			

Please let us know of any medical conditions, such as allergies, epilepsy, mobility, sight, hearing or other specific challenges that we might need to know of. This information will help us ensure that safety and wellbeing are maintained at all times:

SECTION 3: MEDICAL

This section should be completed by/with the referring professional

Wellbeing Pathways is aimed at helping those with low to moderate mental health needs. Please inform us of mental health support needs and any diagnosis, if applicable:

Is there a current care plan / risk assessment? **Yes☐ No ☐**

If 'yes', this must be included with this referral.

Is there a history of self-harm or suicidal behaviour(s) **Yes☐ No ☐**

Is there a history of violent behaviour **Yes☐ No ☐**

If the answer to any of the above is 'yes', please provide details, specifically informing us of when the person last presented with the behaviour(s). This is so that we may ensure safety and wellbeing for all.

CONTACT INFORMATION OF PROFESIONAL MAKING THE REFERRAL:

Referrer Name:	Organisation:
Phone number:	Address:
Email:	

I confirm that the health details on this form are correct, to the best of my knowledge.

Referrer's signature…….. Date ……..

Please send completed forms to referrals@lindengate.org.uk or Lindengate, The Old Allotment Site, Wendover Road, Aylesbury, HP22 6BD.

SECTION 3: CONSENTS

Please provide details of your GP or other health professional involved in your care:

Name:	Job Title & Organisation:
Phone number:	Address:
Email:	

HEALTH CONSENT

I understand that if Lindengate needs to contact any afore mentioned health professional(s) to obtain further information to assess support needs, that the details will be stored securely.

PHOTOGRAPH/VIDEO CONSENT

It is Lindengate's policy that consent must be obtained by the appropriate person in order to use an image (photograph or video) for materials in the public domain. Image consent can be changed or withdrawn at any time by notifying a member of staff. However, we cannot withdraw images already published.

Please tick the boxes below to indicate your consent:

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

COLLECTING FEEDACK

I understand that Lindengate will collect feedback and comments. This information provides evidence of the impact of our services which is used to support fundraising and publicity.

DATA PROTECTION

I understand that all information provided on the registration form and in any further correspondence with Lindengate will be treated as confidential and held on a secure database.

I understand that if Lindengate is under a duty to disclose data, in order to comply with any legal obligation e.g. safeguarding children or vulnerable adults, acts of terrorism or money laundering, they are obliged to cooperate.

I understand the statements above and give my consent

Signature …….. Date……

Name ……

Please send completed forms to referrals@lindengate.org.uk or Lindengate, The Old Allotment Site, Wendover Road, Aylesbury, HP22 6BD.

SECTION 4: EQUAL OPPORTUNITIES MONITORING FORM (Optional)

How would you describe your ethnic origin? Please tick where appropriate.

Asian or Asian British

☐ Indian

☐ Pakistani

☐ Bangladeshi

☐ Chinese

☐ Other Asian background _____

Black, Black British, Caribbean or African

☐ Caribbean

☐ African

☐ Other Black, Black British or Caribbean Background _____

Mixed or Multiple Ethnic Groups

☐ White and Black Caribbean

☐ White and Black African

☐ White and Asian

☐ Other Mixed or multiple ethnic background _____

White

☐ English, Welsh, Scottish, Northern Irish or British

☐ Irish

☐ Gypsy or Irish Traveller

☐ Roma

☐ Other White background _____

Other ethnic group

☐ Arab

☐ Other ethnic group _____