Sunny Bank Psychiatric Rehabilitation Services

Please Fax or Email Completed referral to-

Email. hello@sunnybankprs.co.uk | Tel. 01204883621 | Fax. 01204888947

Referral Type (Circle type of referral below)-

*Residential / *Daycare / *Supported Accommodation

*PLEASE REFER TO CRITERIA FOR CARE/SUPPORT SECTION ON WEBSITE

Name of Client:	Date of Referral: D.O.B:
Client Currently Residing at: Tel:	
Client Usual Address: Tel: Type of Accommodation: (on own or with others?) Close Relative/Friend: Tel:	Does Client: 1. Know of referral: YES / NO 2. Consent to us receiving info: YES / NO 3. Want to come/receive care: YES / NO Please complete the "Permission to Access Notes" on page 4 for client's written permission to see notes / talk to others if the referral is progressed.
Is the client the subject of a DOLS: YES / NO	Have you assessed the client's mental capacity to make the choice re. coming to Sunny Bank PRS: YES / NO
MHA Status (incl. Sec 117): **(We are unable to take Sec. 37/41)**	CPA:
Consultant: Hospital:	Care Co-ordinator:
Any Other Professionals Involved (Name, Profession, Tel): 1. Tel: 2. Tel:	
Reasons for Referral: (i.e. needs, main problems, desired goals).	
Long Term Goals: (i.e. accommodation, lifestyle, activities, social network).	
Family/Social Network: (i.e. relationships, roles, dependencies).	

Referred By:	**Position:**
Referred By Address: Your Tel: Your Email: Your Fax:	
How Did You Hear of Sunny Bank PRS:	

Current Psychiatric & Behavioural Problems/Events:	Previous Psychiatric & Behavioural Problems/Events:
Current Medication (including attitude):	Current Medication Problems (i.e. illnesses, sensory loss, disability):
Any Forensic History (including date & offenses):	Any Drug/Alcohol Abuse:
Past Medical History:	Any Know Allergies (e.g. medication or food):
Any Identified Communication Needs:	Current Covid Status: Dates had Covid or N/A: Had 1st Vaccination? YES / NO Had 2nd Vaccination? YES / NO Had Booster? YES / NO Medically Exempt for Vaccination? YES / NO Deemed "extremely clinically vulnerable" by Government under Covid guidance? YES / NO
Usual Day Time Activities (e.g. work, education, interests/hobbies, daily living skills, use of mental health resources, level of motivation):	
Availability for Assessment / Receiving Care:	
Please attach to this form any Community Care Assessment & Risk Assessment: The referral cannot be progressed without this information due to CQC Requirements.	

Please print or photocopy this blank form if you wish to make a referral.

Sunny Bank PRS
Permission to Access Information

To whom it may concern,

I, _____ am being assessed with a view to provision of care/ support by Sunny Bank PRS for residential / day care / supported accommodation*.

* = Circle type of referral

To assist in my assessment, I would be grateful if you could supply Mary Freeman / Shabnam Nazir / Clare Cummins with verbal and /or written information and access to my notes regarding my previous care/ support and history.

Sunny Bank PRS MUST receive this completed form by email, fax or post prior to any visit.

Thank you for your help in this matter.

Signature: _____ Date: / /

Witness's Signature: _____ Date: / /

Witness's Signature: _____ Date: / /

All information will be securely stored and treated in strictest confidence. Information provided by the Referrer and potential client will be entered on to our secure database and used for the purpose of assessing the suitability of the referral. Please see the following page on our website for our privacy notice:
http://www.sunnybankprs.co.uk/privacy-policy/

Please print or photocopy this blank form if you wish to make a referral.