Referrals will be accepted where the person is experiencing a mental health problem or is at imminent risk of experiencing one and is able to work safely on an allotment. The information you provide on this form will be discussed with the client.

|  |  |
| --- | --- |
| **Name of person referred** |  |
| **Date of Birth** |  | **Phone Number** |  |
| **Address** |  |
|  |
| **Ethnicity** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of main carer** |  | **Phone Number** |  |
| **Address** |  |
|  |

|  |  |
| --- | --- |
| **Name and contact details for social worker, CMHN or other relevant third party** |  |

|  |  |
| --- | --- |
| **Nature of mental health difficulty, including details of any on-going risk of self-harm or harm to others, effects of medication etc.** |  |
| **Nature of any physical health problem that we need to take into consideration** |  |
| **Any other information that may affect the person’s ability to use SAGE Greenfingers e.g. drug/alcohol use, criminal convictions** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Is their tetanus vaccination up to date?** | Yes | No | Not Vaccinated | Unknown |

|  |  |  |  |
| --- | --- | --- | --- |
| **Would they prefer a home visit first?** | Yes | No |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Do we need an interpreter?**  | Yes | No |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Is the person being referred eligible for a personal budget/self-directed support?** | Yes | No | Unknown |

|  |  |
| --- | --- |
| **Please tell us how you heard about SAGE Greenfingers** |  |

|  |  |
| --- | --- |
| **Name of referrer in Primary Care** |  |
| **Name** |  | **Email** |  |
| **Address** |  |
|  |
| **Telephone** |  | **Date of Referral** |  |