PLEASE COMPLETE AND RETURN THIS PAPERWORK TO HEADS UP WITH AND UP TO DATE RISK ASSESSMENT.

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| **Name of Client:** | **Date of Birth:** |
| **Address: Telephone No:**    **Mobile No:**  **Email address:**  **Ethnicity** (Please tick):  White: 󠄀󠄀 British 󠄀󠄀 Irish 󠄀󠄀 Other  Asian or Asian British: 󠄀󠄀 Indian 󠄀󠄀 Pakistan 󠄀󠄀 Bangladeshi 󠄀󠄀 Other  Black or Black British: 󠄀󠄀 Caribean 󠄀󠄀 African 󠄀󠄀 Other  Mixed: 󠄀󠄀 White and Black Caribean 󠄀󠄀 White and Black African 󠄀󠄀 White and Asian 󠄀󠄀 Other  Chinese or other ethnic group: 󠄀󠄀 Chinese 󠄀󠄀 Other  Undisclosed: 󠄀󠄀 Do not wish to answer | |
| **Referral type** (please tick):   * Referred by Social Services * Referred by Somerset Partnership * Referred by Adult Social Care Team * Other (Please specify eg. Self referral, Job Centre)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Activities** (Circle the ones of interest):  Futures Bright Course Pottery Gardening Arts and Craft Group  Woodwork Wellbeing (walking, cooking etc)  **Please note, we will always do our very best to prevent disruption to any of our workshops however from time to time the need may arise for us to allocate you to a different workshop eg. During staff A/L or sickness etc.** | |
| **Attendance** (Circle the ones of interest):  Monday Thursday Half day  Tuesday Friday Full day  Wednesday | |
| **Referrer details (if applicable):**  Name:  Organisation:  Position:  Address:  Telephone:  Email: | |
| **GP details:**  Name:  Address:  Telephone:  Email: | |
| **In case of emergency please contact** (Next of kin or significant other):  Name:  Relationship:  Address:  Telephone:  Email: | |
| **Reason for Referral:**  What is the main reason for your referral to Heads Up?  Summary of mental health and how it affects you? (please provide information about triggers, anniversaries etc)  Do you feel you would be able to ask a member of staff for help if you were feeling unwell while you were at Heads Up? Yes 󠄀󠄀 No 󠄀󠄀  If not, what signs should staff look out for when you are unwell?  What type of help would you like from staff at Heads Up if you are feeling unwell?  󠄀 Would you like us to sit and talk with you?  󠄀 Call your care co-ordinator or a friend or family member? Please specify who;……………………….  󠄀 Arrange for your transport to come earlier than planned?  󠄀 Other, please specify; | |
| **Risk Assessment:**  While this can be a difficult area to discuss we do have an obligation to ensure your safety and the safety of others while attending the workshops at Heads Up. Just because you may answer ‘yes’ to one of the tick boxes below it doesn’t immediately suggest that you will not be able to use our service.   |  |  | | --- | --- | | Harm / abuse towards others: | Harm / abuse caused by others: | | 󠄀 Thought of harming others | 󠄀 Victim of exploitation | | 󠄀 Verbal abuse / threats | 󠄀 Victim of assault | | 󠄀 Physical assault | 󠄀 Has been a victim of abuse | | 󠄀 Sexual assault |  | | 󠄀 Neglect of a dependent |  | |  |  | | Deliberate self-harm: | Other: | | 󠄀 Threats to harm yourself | 󠄀 Careless smoking | | 󠄀 Thoughts of harming yourself | 󠄀 Arson | | 󠄀 Incidents of harming yourself | 󠄀 Property damage | | 󠄀 Suicidal thoughts/urges/threats | 󠄀 Wreck less driving | | 󠄀 Suicide attempts |  | |  |  | | Non deliberate self-harm: | Clinical risk: | | 󠄀 Neglect of diet | 󠄀 Drug abuse | | 󠄀 Neglect of physical health | 󠄀 Alcohol abuse | | 󠄀 Neglect of self-care | 󠄀 Delusions | | 󠄀 Neglect of personal safety | 󠄀 Visual/auditory hallucinations | | 󠄀 Domestic risk | 󠄀 Medication non-compliance | | 󠄀 Road safety risk | 󠄀 Disengagement from care | | 󠄀 Financial vulnerability |  | |  |  | | |  | | --- | | Social vulnerability: | |  | | 󠄀 Social isolation |  | |  |  |   Please use the space below to provide any details to any of the above areas that you may have selected ‘yes’ to: | |
| **Details of current medication and any known side effects:** | |
| **Does the applicant have any particular cultural, ethnic, religious or other specific needs?** (Please tick)  󠄀 Yes  󠄀 No  If yes, please give details: | |
| **Does the applicant have any physical disability and/or additional physical needs?** (Please tick)  󠄀 Yes  󠄀 No  If yes, please give details:  **Do you have any allergies that we need to be aware of?**  (Eg. Do you need to use an epipen if explosed to the allergen) | |
| **Payment and Transport:**  How will you be paying for the Workshop that you attend?  󠄀󠄀 Self funded (cash / cheque / BACS)  󠄀󠄀 Direct payments  󠄀󠄀 Other, please specify;  Who will be managing your payments if you are entitled to Direct Payments?  󠄀󠄀 Enhem  󠄀󠄀 Self Managed  Who will be managing your payments if you are self-funding?  󠄀󠄀 Yourself  󠄀󠄀 A carer or other nominated person (please detail below)  Has your claim for Direct Payments been authorised, if so by who?  󠄀󠄀 Yes  󠄀󠄀 No  󠄀󠄀 Please specify;  How will you travel to and from Heads Up?  󠄀󠄀 Public Transport (Bus / Taxi)  󠄀󠄀 Drive myself  󠄀󠄀 Transport is funded and arranged by my referrer  Contact name and telephone number of your transport operator: | |

Declaration:

* I agree to abide by the aims and formailities of Heads Up and by the policies in place regarding the use of the service.
* I understand that whilst in attendance at Heads Up I am fully responsible for myself.
* I understand that whilst in attendance at Heads Up I need to where suitable clothing that is appropriate to the workshop I am attending. (Suitable PPE is provided where necessary.)
* I agree that any information that I provide may be stored in accordance with the General Data Protection Regulation 2018 and relevant internal policies. I understand that this information will not be shared with any other organisations without my explicit consent, except in situations where I disclose information which suggests that there may be a risk to myself and/or others.
* I understand that I will continue to be charged even if I do not attend except in exceptional circumstances at the managers discretion.
* I understand that my placement at Heads Up is under continual review and that the occasion may arise when we need to end your placement at the service due to us being unable to accommodate and suitably meet your needs.

**Declaration to be signed by client:**

I have read, understood agreed with and completed all the questions on the form:

Signature ...................................................................... Date: ................................................................

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| **Declaration to be signed by the referrer**  I have read, understood agreed with and completed all the questions on the form to the best of my knowledge and enclose an up to date full risk assessment to support my clients referral:  Signature …………………………………………………………………………………… Date ………………………………………………… |

**Client Consent to take and use Photographs, Video & Creations**

Heads Up likes to use client photographs and video on its Website, Facebook page and other social media to show active participation in activities undertaken and to promote our service. In addition we like to exhibit creations produced by you within our workshops, around the service and at outside events. Heads Up holds a Client data base that we use to make contact regarding our workshops and specific Client events. Heads Up does not share or pass your data to any third parties.

Please let us know if you agree to us taking your photo and using it on our website, Face book, and other publicity material by selecting from the options below (this includes creations produced within workshops).

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| --- | --- | --- | --- |
|  | **YES** | **NO** | (Please tick the appropriate box) |
|  |  |  | Agree to have your photograph taken in an individual or group (please delete as appropriate) setting. |
|  |  |  | Agree to have video imagery of you taken in an individual or group (please delete as appropriate) setting. |
|  | Agree to the use of photographs and/or videos (please delete as appropriate) on the Heads Up;  󠄀 Website  󠄀 Facebook and other social media  󠄀 Within newspaper and other magazine publications  󠄀 Within the service | | |
|  | Agree for items that you have created and photographs of items created by you to be displayed in our;  󠄀 Workshops  󠄀 Within the service  󠄀 At external events | | |
|  | Agree for photographs of you and/or items you have created to be used as content within;  󠄀 Our annual review, promotional booklets, leaflets/flyers  󠄀 Our pop up banners and table banners  󠄀 Newspapers and magazine publications | | |
|  |  |  | Memories clients only:  Agreethat photographs and personal history information can be displayed on the walls of the memories room (in poster form). Please note that this room is used for other purposes e.g. Training, meetings and by outside visitors. |

**PLEASE NOTE:** Consent to take/use photographs, video or items created may be withdrawn at any time by informing the Data Privacy Officer or speaking to any Staff member.

Name:………………………………………………

Signature:…………………………………………

Date:………………………………………………..

(If you are signing on behalf of someone please include their name:………………………………)

**Client Consent to Release Information**

Occasionally Heads Up staff are asked to share information about you to a Health Care Professional or your Next of Kin for example. To ensure that we get this right and that we act in a manner that has been agreed by you we need your consent.

I……………………………………….. hereby give permission for Heads Up staff to release information to:

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| --- | --- |
| Who: | In regards to:  (Please tick the appropriate boxes) |
| Statutory Organisations, including my Care Coordinator, the duty worker in the absence of my Care Coordinator or a GP at my registered surgery. | * My Mental Wellbeing and Physical Health * My progress within Heads Up |
| A family member, Carer or Next of Kin  Please Specify:  1)……………………………………………………  2)…………………………………………………...  3)…………………………………………………… | * My Mental Wellbeing and Physical Health * My progress within Heads Up |

**PLEASE NOTE:** Consent to release information to the individuals that you have named above can be reviewed at any time by speaking to the Data Privacy Officer or any member of staff.

I understand that this information will not be shared with any other organisations without my consent, except in situations where I disclose information which suggests that there may be a risk to myself and / or other or a Safeguarding concern.

Name:………………………………………………

Signature:…………………………………………

Date:………………………………………………..

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| **Our Mission Statement** |
| “Improving the Mental Health and wellbeing of adults through Empowerment, Support and Hope.”  Heads Up provides activity based learning and development workshops for individuals with mental health needs, including adults with dementia, learning disabilities and physical disabilities. |
| **Our Aims** |
| We provide support to enable individuals to establish links to their local community and in particular access information such as education, volunteering and employment opportunities. Our main aims embed and embrace the Five Ways to Wellbeing and are to:   * Support clients to access socially inclusive mainstream activities and services, providing an opportunity to meet others and form social networks * Learn a new skill or even rekindle an old interest by participating in a creative activity * Improve physical and mental health through exercises eg. Walking, tai-chi, gardening * Improve mental health and emotional wellbeing by nurturing and understanding your needs, including relaxation techniques, listening to music, being creative * Help, encourage and share knowledge and skills with others. |
| **A few Formalities** |
| Individuals must abide by the Health and Safety Practices in place at the service.  No one will be allowed on the premises if they are under the influence of or in the possession of alcohol, legal highs or illegal drugs.  All individuals are treated equally and are respected at Heads Up. All contributions are considered valuable and worthwhile.  The only dogs allowed in the unit are assisted dogs.  Smoking is only permitted within the designated smoking area, this includes vaping and the use of electronic cigarettes.  Aggressive or abusive behaviour will not be tolerated.  Unfortunately, due to insurance purposes, children under the age of 15 are not permitted on site. |

**Heads Up Referral Guidance Notes**

**Information for Referrers**

The referral should be completed with the person thinking about attending Heads Up, unless you are making a self referral.

In order to process referrals, each part of the form should be completed in full. It is advisable to consider the Heads Up Eligibility Criteria at the time of referral.

Heads Up work to a multi-agency approach and expect that all information appropriate to the referral is shared to support our work. All information contained within the referral will be discussed with the person during their assessment.

We request that you return the completed referral form with an up to date care plan and risk assessment if these are available.

Once we have received completed referral paperwork and supporting documents, we will endeavour to process it within 7 working days. The Service Manager or Deputy Manager will make contact with the referrer and referee to arrange a suitable time to visit the service to look around and to have an assessment.

All referrers and referees will be notified after their assessment the outcome of the referral.

Heads Up aims to support everyone who is eligible to use its service.

**Heads Up Referral Guidance Notes**

**Eligibility Criteria**

1. Clients will be aged 18 and over.
2. Clients will NOT be in a state of crisis at the time the referral is made.

1. Clients with an active drug (legal and/or illegal) or alcohol related problem will be considered as long as they are already accessing and engaging with appropriate support services.
2. Clients will have a commitment to working towards achieving their personal goals.
3. All prospective clients will be assessed to ensure that Heads Up is able to meet their needs.
4. Clients will currently be in need of Heads Up services, but if there comes a time when the level of support is no longer necessary they will be supported to move on.
5. All clients should be prepared to work in partnership with staff to plan goals and set individual aims.

**FOR OFFICE USE ONLY (HEADS UP)**

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| **ASSESSMENT**  Client (name)....................................................................... assessed by ...........................................  on ..................................................................... for .........................................................................  Comments: |
| **RISK SCREENING & SELF MANAGEMENT**   1. Summary of Risk Factors including historic and current risks including incidents of agressive behaviour, self harm, addiction etc. 2. Summary of Risk Management: 3. Summary of who to contact in the event of risk escalation eg. Next of kin, care co-ordinator etc. |