Client Referral / Assessment Form & Service File sheet

MSH Service (please select the relevant service):

	BME Family Service		**Day Service**		**Advocacy Service**

What is the purpose of this form? (PLEASE READ)

There are three parts to this form:

Part A – Referral Form: Allows MSH to provide an initial assessment to see if you are eligible to access their services. The form can be completed by you, with a member of the MSH team or by a referring agency.

Part B – Service Assessment Form: If MSH consider you eligible to access one of their services following the initial assessment, a more in-depth assessment of you support needs will be conducted.

Part C – Service File Information: Once a full assessment of your service needs has been conducted, you will be allocated a MSH Keyworker and a personal file relating to the service(s) you are accessing will be created so that we can keep a record of all activity relating to your support needs in one place.

PART A Referral Form

The information collected in this form is to help us, help you. All information will be kept private and confidential and is underpinned by our Privacy Policy and in accordance with the Principles of the General Data Protection Regulation (GDPR), and Data Protection Act 2018. All information detailed in this form, along with information we receive about you will be available to you on request.

We require your explicit consent to collect sensitive personal information about you which includes your race, ethnic origin, religion, and health (*see the ICO for more information*). Under the Principles of the GDPR you have the right withhold consent for processing your personal information, however you should be aware that this may impact on the level of service we are able to provide - if you would like to have a chat about this further please speak to a member of the MSH team.

For monitoring and evaluation purposes we are required to share your personal information with our funders, which includes Liverpool City Council, in order to report on the impact our services are having on our clients and wider BME community in Liverpool.

Personal Details

Full Name:		**Date of Birth:**	/ / 19	**Age:**	
Telephone number:		**Address:**			
		Postcode:			
Racial Background:			**NI:**		

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Next of Kin

Full Name:		**Relationship:**	
Telephone number:		**Address:**	
		Postcode:	

GP / Family Doctor

DR/GP Name:		**Telephone number:**	
Address:			
		Postcode:	

Other Services

Are you involved in any other services (psychiatrist, social services)?	**Yes**		**No**	

If 'yes' please detail below:

Service:		**Contact Name:**	
Hospital (if applicable):		**Address:**	
	Postcode:		
Telephone number:			

Service:		**Contact Name:**	
Hospital (if applicable):		**Address:**	
	Postcode:		
Telephone number:			

Service:		**Contact Name:**	
Hospital (if applicable):		**Address:**	
	Postcode:		
Telephone number:			

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Medication

If you are currently using medication please detail below:

Medication Name	Dosage
1.	
2.	
3.	

Further Information

Is there anything else you would like us to know about you? Do you have a mental health diagnosis?

- ☐ I consent to MSH using the personal information provided detailed in this form to assess my needs for access to their services.
- ☐ I consent to MSH sharing the personal information detailed in this form with its funders (which includes Liverpool City Council) for monitoring and evaluation purposes.

Client name:_____ **Client signature:**_____

Date:_____

Form completed by:		**Date:**	
Referred by Name:		**Organisation:**	

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PART B Assessment Form

Assessment Date:		**Preferred Language:** **Interpreter required:**	Y / N

IDENTIFIED NEEDS

Support needs	Insert 'H', 'M', 'L' – High, Medium, Low	Description
Housing / Tenancy		
Aids & Adaptation: **Home** **Personal**		
Welfare Benefits		
Personal Budgets		
Parenting / Children Issues **Childcare** **School** **Other**		
Health / Disability Issues		
Education / Training / Employment		
Counselling		
Form filling / letters etc		
Domestic issues		
Language Support		
Advocacy		
Home Support		

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Personal Assistant **Personal Care**		
Other		

FAMILY MEMBERS

Name	Date Of Birth (D.O.B)	Relationship to client
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Brief Family Mental and/or Social History

Benefits:

1.
2.
3.
4.

Risks Identified

1.

2.

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3.

4.

5.

PART C Service File Information

Keyworker Allocation (please tick next to allocated keyworker)

Saiqa Sahotra	
Julie Roberts	
Social Work Student. Name:	
Kellie Rostron	
Fouzia Hinchliffe	
Simon Torkington	
Alex Coombes	

	Would like support with	Expected Outcome
Mental Health Needs		
Physical Health		
Attending Appointments (Psychiatrist, GP, CAB)		
Finances (Debt, Benefits, Budgeting)		

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Social Inclusion (Travelling, Volunteering, Attending Activities/Courses)		
Life Skills (Housework, Cooking, Cleaning, Laundry, Shopping)		
Housing (Security and Maintenance of Property)		
Dealing with a crisis		
General Counselling		
Counselling (Talk Liverpool)		
Advocacy Support		
Other (please specify):		

	Would like to be involved in	**Expected Outcome**
Aromatherapy (Alternate Monday's)		
Art Class (Monday's)		
Men's & Women's Group (Wednesday's & Saturday's)		
Other Activities (walking groups, cycling group, culinary collaboration)		
Employment, Education and Training (Advocacy Training, Positive Progress)		
Stress Management Classes (Talk Liverpool)		
Awareness Raising Events		
In-house Events		