Self-Referral Form

Please first download this form before editing fields.
Data entered within an internet browser may not be saved!

Form to be completed by the person referring themselves and sent to the address on back page.

Please note: There is an assessment and/or a trial period of 4 weeks and the offer of a place is not automatic.

All information provided will be kept strictly confidential and not shared outside of Lindengate staff without your written permission.

Date of referral:

Your details:

☐ Male ☐ Female

Last name:

First Name:

Street Address:

City:

County:

Post Code:

Date of birth:

Home Number:

Mobile Number:

Email Address:

Lindengate 2016. All rights reserved.

What is your reason for seeking a placement with Lindengate?

How would you describe your physical health?

How would you describe your current mental health?

If you have a diagnosis, please give details

What other Services are currently helping you with your physical and/or mental health issues?

Please give the name(s) and address(es) of those services (if applicable)

Lindengate 2016. All rights reserved.

Do you need any help with communication? If yes, please give details.

Are you currently taking any medications? If so, what?

What do you do to keep yourself well?

Is there any other information that you feel we should know?

Please list any known allergies, including food allergies that we should be aware of:

Lindengate 2016. All rights reserved.

(If you have answered yes to any of these questions, then you will not necessarily be excluded from attending but the information will help Lindengate to work with you more effectively)

Do you have a history of self-harm?	Yes	No
Do you have a history of suicidal behaviour?	Yes	No
Do you have a history of violence towards others?	Yes	No
Do you have any criminal convictions?	Yes	No
Do you have a history of alcohol misuse?	Yes	No
Do you have a history of drug misuse?	Yes	No

If you have answered yes to any of the above questions, please give details:

GP contact:

Contact name: Dr

Phone no:

Surgery Address:

Mobile:

If we need to contact your GP are you happy to give consent for this? ☐ Yes ☐ No

Lindengate 2016. All rights reserved.

Emergency Contacts:
In the event of an incident on site who should we contact (family member, mental health, worker, friend)?

First contact name: | Home number: | Mobile number:

Relationship to individual:

Address:

Second contact name: | Home number: | Mobile number:

Relationship to individual:

Address:

I certify that the information given in this form is correct

Signed **Date**

Initial Visit Details (to be completed by Lindengate staff)

Date | Time

Please return your completed form by email to: referrals@lindengate.org.uk

Or by post to: **Service User Manager** **Phone: 01296 622443**
Lindengate
World's End Garden Centre (Wyevale), Old Allotment Site
Aylesbury Road
Wendover
Buckinghamshire. HP22 6BD

Please mark as "Private and Confidential"

Lindengate 2016 All rights reserved.