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**Touchstone: Wakefield Community Enablement Team**

**Referral Form**

**Wakefield CET Referral Criteria & Process**

Individuals referred to our service must meet the following criteria:

1. Be aged 16+
2. Be a resident of Wakefield & District
3. Be impacted by Complex Mental Health Needs
4. Be at risk of one or more of the following:
   * Deterioration of mental health
   * Tenancy related issues or homelessness
   * (Re)admission to hospital
   * (Re)offending.

## We are a non-clinical team, and may not be able to support individuals if:

* They need crisis support.
* They need acute mental health support.
* We are unable to offer 1-1 support safely
* They are not currently able or willing to engage in 1-1 recovery-focused support

The Referral Process:

1. Check on our webpage to see if referrals are open: [CET Webpage](https://touchstonesupport.org.uk/wakefield-community-enablement-team/)
2. Complete the referral form and email it to

[wakefield-CET@touchstonesupport.org.uk](mailto:wakefield-CET@touchstonesupport.org.uk)

Include a safety/wellbeing plan/ assessment or WRAP if relevant.

1. A CET Worker will arrange an in-person meeting with the referred individual. We will ask if referrers can attend this, to ease the transition between services.
2. Following the meeting, a decision will be made by our team. The referrer will be informed (usually by email).
3. If we do not feel we are the right service for the individual or are unable to offer support, we are committed to signposting to other services. We do not hold a waiting list.

You can find a more in-depth guide to our referral process on our website.

There is also a guide for individuals being referred to our service. We ask that you share this with the individual being referred so they are aware of the process.

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**Touchstone:**

**Wakefield CET Referral Form**

**2025**

**Client Details:**

|  |  |
| --- | --- |
| Title: |  |
| Pronouns: |  |
| First Name(s): |  |
| Surname: |  |
| Preferred Name: |  |
| Date of Birth: |  |
| Age: |  |
| Contact Number: |  |
| Full Address (including Postcode): |  |

**Referrer’s Details:**

|  |  |
| --- | --- |
| Name: |  |
| Organisation: |  |
| Address: |  |
| Telephone |  |
| Mobile |  |
| Email: |  |
| How Long have you known the client? |  |
| How often do you have contact with the client? |  |

**GP’s Details:**

|  |  |  |
| --- | --- | --- |
| **Name:** |  | |
| **Address:** |  | |
| **Telephone:** |  | |
| Does not have a GP. | Details Unknown | Refused to give details |

**Other Support:**

Please provide the name and contact information for other services, organisations or individuals (including family and friends) who are involved in the client’s support.

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Role/Relation to client | Contact Details  (number and/ or email) | Support provided: |
|  |  |  |  |
|  |  |  |  |

**Reason for Referral:** Please answer the below questions, providing as much detail as possible.

|  |
| --- |
| Please explain how the individual meets the referral criteria detailed on page two: |
|  |
| Individuals referred to our service must be at risk in one of the following areas. Please select those which apply: |
| (Re) Offending  Homelessness or Tenancy related issues  Deterioration of Mental Health, including risk of re-admission/admission to hospital. |
| Please give details of any presenting issues and relating support needs:  (Example 🡪 The individual is struggling to manage their finances and needs to apply for Universal Credit. They need support accessing services to help them with this, as they also struggle with agoraphobia and social anxiety and are currently unable to independently reach out to Citizens Advice.) |
|  |

**Mandatory Questions:** These are designed to give us a broader picture of the referred individual, and any safeguarding concerns or lone-working risks.

|  |  |
| --- | --- |
| Mental Health | |
| Is the individual experiencing mental health issues? | Yes  No |
| If yes, please provide details.   * Diagnosis * Symptoms & Impact on daily life * Hospital Admissions * Suicidal ideation or Self-harm |  |
| When did this occur? | Current  Historic (12 months +) |
| Physical Wellbeing | |
| Are there any physical health issues? | Yes  No |
| If yes, please provide details:   * Diagnosis * Symptoms * Impact on daily life |  |
| When did this occur? | Current  Historic (12 months +) |
| Offending: | |
| Is there an offending history? | Yes  No |
| If yes, please provide details:   * Details of Offence * Current Status (on bail, license) * Further Context |  |
| When did this occur? | Current  Historic (12 months+) |
| Violence (including use of OR carrying weapons), harassment, threats, aggression, verbal abuse, inappropriate behaviours (including sexual offences/stalking, etc.) | |
| Is there history of violence? | Yes  No |
| If yes, please provide details:   * What occurred, when and towards whom? * Likelihood of reoccurrence |  |
| When did this occur? | Current  Historic (12 months+) |
| Safeguarding | |
| Is the individual able to keep themselves safe? | Yes  No |
| If yes, please provide details:   * Any history of exploitation * Vulnerability to harm from others |  |
| When did this occur? | Current  Historic (12 months+) |
| Drug Usage (illicit or misuse of prescription medication) | |
| Is there current / historic use of substances? | Yes  No |
| If yes, please provide details:   * Substances used * Duration/ frequency of use * Impact on daily life |  |
| When did this occur? | Current  Historic (12 months+) |
| Alcohol Misuse | |
| Is there current /historic use of alcohol? | Yes  No |
| If yes, please provide details:   * Frequency of Use * Impact on daily life * Insight and understanding of this |  |
| When did this occur? | Current  Historic (12 months+) |
| Lone Working **(including any Pets)** | |
| Would there be any concerns of staff lone working? | Yes  No |
| If yes, please provide details:   * Previous concerns * What occurred & When * Factors relating to incident |  |
| When did this occur? | Current.  Historic (12 months+) |
| **NOTE:** If the client has a wellbeing /safety plan please provide a copy of this when sending the referral form. | |

**Monitoring**: **Please complete the tick-boxes below.** This information is requested by our funders. The answers you give will not influence our decision to offer the applicant support.

|  |  |
| --- | --- |
| Gender: | Male. Female. Non-Binary. Trans. Other Prefer Not to Say |
| Is your gender identity the same as the gender you were assigned at birth? | Yes No Prefer Not to Say |
| Marital Status | Married. Single. Co-Habiting. Civil Partnership.  Prefer Not to Say. Other (Please State) |
| Sexual orientation | Gay. Lesbian. Bisexual. Heterosexual/Straight.  Prefer Not to Say. Other (Please State) |
| Ethnic Origin | **White:**  English. British. Irish. Northern Irish. Scottish. Welsh.  Gypsy /Irish Traveller. Other (Please State) |
| **Asian or Asian British:**  Indian. Pakistani. Bangladeshi. Kashmiri. Chinese  Other (Please State) |
| **Black or Black British:**  Caribbean. African. Other (Please State) |
| **Dual Heritage:**  White/ Black Caribbean. White/Black African. White/Asian.  Other (Please State) |
| Any Other Ethnicity (Please State)…… Prefer Not to Say. |
| Residency | British Citizen. Asylum Seeker. EU National.  Foreign Student.  Refugee. Prefer Not to Say. Any Other (Please State) |
| Religious/spiritual Beliefs: | Christian. Jewish. Hindu. Sikh. Buddhist. Muslim. Atheist. Jehovah Witness. No Religion. Prefer Not to Say. Other (Please State) |

|  |  |
| --- | --- |
| Does the Client define themselves as disabled? | Yes  No  Prefer Not to Say |
| Please tick those which apply: | Learning Disability  Physical Disability  Sensory Disability  Dementia  Mental Health Condition  Autism  ADHD  Other (Please State) …………………………….. |
| Does the client have a specific condition or diagnosis? | Yes  No |
| Specify diagnosis here: |  |
| Does the client have any communications or literacy needs? | Yes  No |
| Please provide details: |  |

**Further Information:**

|  |  |
| --- | --- |
| Is the client a parent? | Yes  No |
| Are the children living with parents? | Yes  No  N/A |
| **Has the client given consent to share this information? Please refer to the privacy notice** | Yes  No |

|  |
| --- |
| **Important notice:** We are unable to accept referrals without the client’s consent. By providing us with your data you are giving us your consent to process your data.  **You must indicate this.** Please refer to page seven for our full Privacy Statement. |

**Touchstone Service User Privacy Statement:**

**Touchstone is committed to protecting and respecting your privacy and keeping your data secure.** By providing us with your data you are giving us your consent to process your data. We will only process your personal data to provide you with the service that you have requested from us and to provide (anonymous) feedback to our commissioners and funders.

To read our Service User Privacy Notice, please visit: [Touchstone Service User Privacy Notice - OCT 24 .docx](https://touchstoneleeds.sharepoint.com/:w:/r/sites/Wakefield-CET-WKD-MT/Shared%20Documents/WKD%20-MT/CET%20WKD/Service%20operational/IT/Information%20governance/Touchstone%20Service%20User%20Privacy%20Notice%20-%20OCT%2024%20.docx?d=w550aa3210bb8454f965c7d533646332e&csf=1&web=1&e=OYFse7)

Or for our Privacy and Cookies Policy, please visit: Privacy Policy - Touchstone (touchstonesupport.org.uk)

**Thank you for your enquiry to the Wakefield Community Enablement Team.**

Please email the completed referral form and a relevant wellbeing / safety plan/ WRAP to [wakefield-CET@touchstonesupport.org.uk](mailto:wakefield-CET@touchstonesupport.org.uk)

We aim to acknowledge referrals **within 7 days**. Please note that **we do not hold a waiting list**. Our website will notify you if referrals are closed.

[**Website: https://touchstonesupport.org.uk/wakefield-community-enablement-team/**](Website:%20%20https://touchstonesupport.org.uk/wakefield-community-enablement-team/)