

# RESTORE Referral Form

This form aims to help the person think about what they want from being at RESTORE. It also provides us with relevant information to enable a productive placement and safe working environment.

The information on this form is **CONFIDENTIAL**.

Name	
Date	

## 1. What do you want to get out of coming to RESTORE?

This might include gaining practical skills, improving your life skills, feeling better about yourself, meeting more people, or be something as simple as having something different to do.

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## 2. You and RESTORE

Where do you want to go? *(Please circle)*

Elder Stubbs Garden Group    The Beehive  
RESTORE at Fleet Meadow        LEaP

What are your preferred days? *(Please circle)*

Monday    Tuesday    Wednesday    Thursday    Friday

## 3. Your current situation

### Accommodation

Please indicate if you live alone or with others, what type of Accommodation you have, and relevant family/carer relationships.

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### Activities

Please tell us about any activities you are involved in at the moment

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### Employment and Training

Please tell us about any jobs you have or any employment training you are doing at the moment

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**4. What have you done in the past?**

Please include details about your experience of work and training and about things you used to enjoying doing

**5. What is the nature of your mental health problems?**

How does your mental health problems affect you on a day to day basis, including the effects of medication? How has your mental health problem been diagnosed? What are the signs of you being/becoming unwell? What are the risks associated with you being/becoming unwell?

**6. Care Plan/ Risk Assessment**

If you have a Care Plan (CPA) and/or Risk Assessment we will require copies of these. If you have a CPN, a social worker or a psychiatrist you should have one of these. If you cannot get copies yourself we can approach your team for you.

CPA attached  Risk Assessment attached

**7. RESTORE is a work based environment and is subject to the Health and Safety at Work Act. Are there issues relating to health and safety at work we need to be aware of?**

This includes risks of falling, confusion, any past or present issues you may have had related to alcohol, non prescribed drugs, violence and aggression, self harm, and any other issues that you feel may be relevant.

**8. Please describe any physical health problems and the treatment you are receiving for them**

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**9. Any other information relevant to your placement at RESTORE**

**10. Referrer**

Name	
Profession	
Address	
Telephone	

**12. Reviews**

We hold regular reviews of your placement. These provide an opportunity to look at progress and decide personal goals. We are happy to invite other people (either professionals or carers) to these reviews. Who do you want us to invite.

- Referrer (as above)   
No-one   
Someone else (please give contact details below)

Name .....  
Position/Relationship/Team .....  
Address .....  
.....  
.....  
Telephone .....

**11. Signatures**

Service User .....	Referrer .....
Date .....	Date .....

**11. Please return this form to...**

**The Beehive**  
Manzil Way  
Cowley Road  
Oxford  
OX4 1YH  
(01865) 455 829  
[beehive@restore.org.uk](mailto:beehive@restore.org.uk)

**Elder Stubbs Garden Group**  
Elder Stubbs Allotments,  
Rymers Lane  
Cowley  
Oxford  
OX4 3LB  
(01865) 747 176  
[elder.stubbs@restore.org.uk](mailto:elder.stubbs@restore.org.uk)

**LEaP**  
Michael Young Building  
Manzil Way  
Cowley Road  
Oxford  
OX4 1YH  
(01865) 455 825  
[leap@restore.org.uk](mailto:leap@restore.org.uk)

**RESTORE at Fleet Meadow**  
Sandringham Road  
Didcot  
Oxfordshire  
OX11 8TP  
(01235) 817 215  
[south.oxfordshire@restore.org.uk](mailto:south.oxfordshire@restore.org.uk)

# RESTORE Registration Form

We use this information to see who uses our services and what we could do to improve them.  
The information on this form is **CONFIDENTIAL**.

## Personal Details

First Names	
Last Name	
Address	
Post Code	
Date of Birth	
Telephone (day)	
Telephone (eve)	
Email address	

## Main Emergency Contact

Name & Relationship	
Address	
Telephone	

## GP

Name	
Practice	

## Sources of Support

Please give details for the people that support you.

	Name	Address	Telephone
Main Carer			
Psychiatrist			
Social Worker			
C.P.N.			
Support Worker			
Care Coordinator			
Other			

## Data Protection Act 1998

The information you provide on this form is used by RESTORE. RESTORE is registered under the Data Protection Act 1998. This information will be used for administration, monitoring, and to improve our service. It may also be passed to funders. Any information that identifies individuals will only be passed on to organisations that are registered under the Data Protection Act 1998. **The information will only be used for research and monitoring purposes.**

## Ethnicity

<u>White</u>	
British	<input type="checkbox"/>
Irish	<input type="checkbox"/>
Other White	<input type="checkbox"/>
<u>Mixed</u>	
White and Black Caribbean	<input type="checkbox"/>
White and Black African	<input type="checkbox"/>
White and Asian	<input type="checkbox"/>
Other Mixed	<input type="checkbox"/>
<u>Asian or Asian British</u>	
Indian	<input type="checkbox"/>
Pakistani	<input type="checkbox"/>
Bangladeshi	<input type="checkbox"/>
Other Asian	<input type="checkbox"/>
<u>Black or Black British</u>	
Caribbean	<input type="checkbox"/>
African	<input type="checkbox"/>
Other Black	<input type="checkbox"/>
<u>Chinese or Other Ethnic Group</u>	
Chinese	<input type="checkbox"/>
Other Ethnic Group	<input type="checkbox"/>
<u>I do not wish to answer</u>	<input type="checkbox"/>

## Gender

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>
Do not wish to answer	<input type="checkbox"/>

## Dependants

Please list the dates of birth of your children (if any)	
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## Qualifications

None	<input type="checkbox"/>
Below NVQ 1 or equivalent	<input type="checkbox"/>
NVQ 1 or equivalent	<input type="checkbox"/>
NVQ 2 or equivalent	<input type="checkbox"/>
NVQ 3 or equivalent	<input type="checkbox"/>
NVQ 4 or equivalent	<input type="checkbox"/>
NVQ 5 or equivalent	<input type="checkbox"/>
Do not wish to answer	<input type="checkbox"/>

## Benefits

None	<input type="checkbox"/>
Job Seekers Allowance	<input type="checkbox"/>
Incapacity Benefit	<input type="checkbox"/>
Income Support	<input type="checkbox"/>
Disability Living Allowance	<input type="checkbox"/>
Other	<input type="checkbox"/>
Do not wish to answer	<input type="checkbox"/>

If you are not in paid work please put the last date you worked	
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Are you on CPA?	
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## Signature

Signature	_____
Date	_____

## Office Use Only

Start Date	
Service	

**RESTORE: working for mental health**  
Manzil Way, Cowley Road,  
Oxford, OX4 1YH  
Registered Charity Number: 261476