

# i-reach project referral

|                 |                  |  |                      |                      |                      |                      |                      |                      |                      |                      |
|-----------------|------------------|--|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| office use only | referral number: | <input type="text"/>   | <input type="text"/> | <input type="text"/> | -                    | <input type="text"/> | <input type="text"/> | -                    | <input type="text"/> | <input type="text"/> |
|                 | received:        | <input type="text"/>   | <input type="text"/> | <input type="text"/> | -                    | <input type="text"/> | <input type="text"/> | -                    | <input type="text"/> | <input type="text"/> |
|                 | committee:       | <input type="text"/>   | <input type="text"/> | <input type="text"/> | -                    | <input type="text"/> | <input type="text"/> | -                    | <input type="text"/> | <input type="text"/> |
|                 | decision:        | <input type="checkbox"/> approved<br><input type="checkbox"/> not approved |                      |                      |                      |                      |                      |                      |                      |                      |
|                 | date:            | <input type="text"/>   | <input type="text"/> | -                    | <input type="text"/> | <input type="text"/> | -                    | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Please read the Eligibility Criteria and Guidance Notes before completing this form.

|   |                 |
|---|-----------------|
| <b>Type of Referral:</b> <input type="checkbox"/> Individual <input type="checkbox"/> Group | <i>(Note 1)</i> |
|---|-----------------|

|   |  |
|---|--|
| <b>Part 1: Client Details</b>   |  |
| <b>REFERRER PLEASE NOTE – Individual Referrals:</b> To ensure the privacy of your client, names and other personal details should be entered <b>only</b> on this page, which will be separated from the application prior to consideration by the project committee. Personally identifiable information will not normally be seen by staff other than the project administrator. |  |
| Organisation  | <input type="text"/> <i>(if applicable)</i>                          |
| Name  | <input type="text"/> <i>(Note 2)</i>                                 |
| Date of Birth   | <input type="text"/> <i>(if applicable)</i>                          |
| Address   | <input type="text"/><br><input type="text"/><br><input type="text"/> |
| Telephone   | <input type="text"/>   |
| Email   | <input type="text"/>   |

|  |
|--|
|  |
|--|

please do not print this page

do not print the preceding page  
back to back with the subsequent  
pages, as they are to be separated

office use

referral number:    -   -

Individual  Group

## Part 2: Circumstances of person being referred.

### 2.1 Eligibility Criteria

Please indicate which of the eligibility criteria are met by the client or group of clients:

a) Illness  b) Isolation  c) Access  d) Self-Care  e) Specific Support  f) Age

Additional Comments:

*(if applicable)*

### 2.2 Living Circumstances

Briefly describe the living circumstances (e.g. accommodation, social contact) of the person being referred:

*(note 3)*

## **2.3 Current Services**

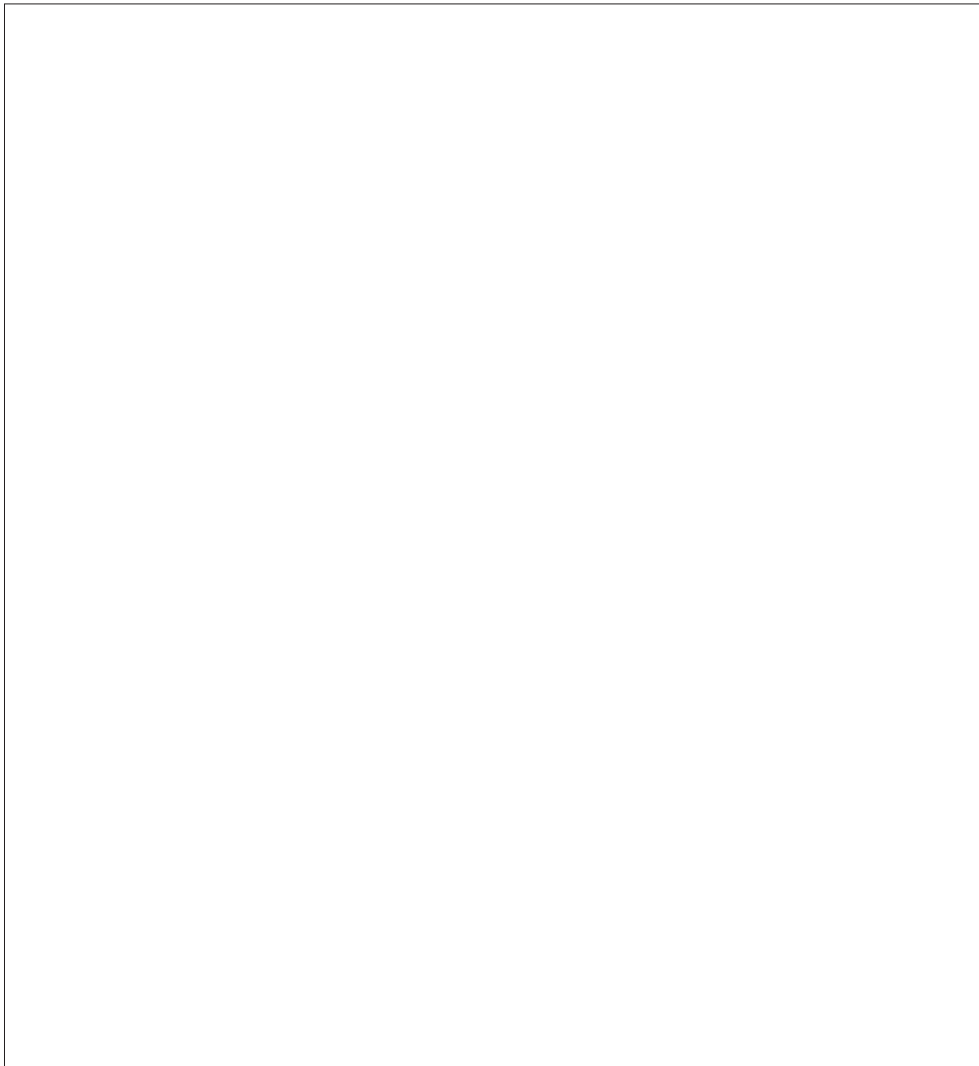
List any services which the client currently accesses:



## **Part 3: Proposed Support**

### **3.1 Your Proposal**

What support would you like to see being provided through the project?



### **3.2 Benefits**

In what way(s) would you expect such support to be of benefit to the client?

### **3.3 Measurement**

How would you know if the above had been achieved?

### 3.4 Consent

Does the person being referred know about this referral? Yes  No

If so have they agreed to it? Yes  No

If the answer to either of the above questions is NO, please give your reasons for proceeding with the application:

### 3.5 Additional Information

Please provide any other information which you consider to be relevant to this referral:

## Part 4: Support Specification and Costs

### 4.1 Timescale

Please give details of timescale for this package, or indicate if it is a one-off item. *(note 4)*

One-Off?

Period  from  *(start date)*

Frequency

Session Length

### 4.2 Specific support measures.

Please provide details and costings for each item proposed, including provider or supplier and total cost for the item:

|      |  |
|------|--|
| Item |  |
|------|--|

*(note 5)*

|        |  |
|--------|--|
| Agency |  |
|--------|--|

*(note 6)*

|      |  |
|------|--|
| Cost |  |
|------|--|

*(note 7)*

|      |  |
|------|--|
| Item |  |
|------|--|

*(note 5)*

|        |  |
|--------|--|
| Agency |  |
|--------|--|

*(note 6)*

|      |  |
|------|--|
| Cost |  |
|------|--|

*(note 7)*

Item

(note 5)

Agency

(note 6)

Cost

(note 7)

Item

(note 5)

Agency

(note 6)

Cost

(note 7)

**4.3 Total Cost**

(note 7)

(If you need to specify further items, reprint this page.)

## Part 5:

### Statement of Referral

I request the funds detailed above to provide the specified support. To the best of my knowledge all financial details are accurate. I will provide all receipts for the above expenditure.

Signed

Date

### Referrer Details

Name

Post

Organisation

Relationship to Client

Address

Telephone

Email

Please return this form to:

**i-reach Project Administrator  
Western Isles Association for Mental Health  
23 Bayhead  
Stornoway  
Isle of Lewis  
HS1 2DU**

*You can fill this form on-screen in using a PDF reader, and print it completed. Contact [info@ireach.org.uk](mailto:info@ireach.org.uk) for advice.*

*You can download this form again at [www.ireach.org.uk](http://www.ireach.org.uk).*