Reconnect

Referrals will only be accepted for individuals that require support accessing and engaging with community-healthcare services and/or support services upon their release. This service is not a replacement for any other existing service and will work alongside other agencies to support successful release into the community.

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| **RECONNECT Referral Form** | | |
| **Date of referral:** | | |
| **Name of individual being referred:** | | |
| **Service name referral:** Choose an item.  **If ‘Other’ was selected, please confirm the name of the referral below:** | | |
| **Prison Number:** | **Date of Birth:** | |
| **Please confirm the individual is aware of the referral and sharing of information.**  **(Please ensure the consent to share information form has been signed by the individual and is included with this referral)**  **Yes** | | |
| **What is the individual’s sex?**  Choose an item. | **Is the gender the individual identifies with the same as your sex registered at birth?**  Choose an item. | |
| **Religion or belief:**  Choose an item. | **Ethnicity:**  Choose an item. | |
| **Sexual Orientation:**  Choose an item. | **Marital Status:**  Choose an item. | |
| **Identified Disability:**  Choose an item.Choose an item. | | |
| **Pregnancy and Maternity:**  Choose an item. | | **Armed Service history:**  Choose an item. |
| **Area the individual will be released to:** | | |
| **Home Address:**  **Please indicate if no fixed**  **abode upon release** | | |
| **Family/ Personal Circumstances (e.g. will this person have family support on release, will they live with family? Support of friends etc.?)** | | |
| **Does the individual have any caring responsibilities?** | | |
| **Release date:** | **Current Risk alerts / ACCT Status:** | |
| **ROTL dates if known:** | | |
| **Is this individual subject to any license conditions? (e.g. geographical tag/curfew etc.)** | | |
| **Does this individual have any restraining orders?** | | |
| **Please identify specific health and treatment needs in the community. (e.g. Accessing Physical Health services, Mental Health / Substance Misuse services)** | | |
| **Is the individual registered with a GP? If yes, please state which GP.** | | |
| **What are the identified challenge/s to accessing treatment for this individual?** | | |
| **Are there any concerns about a successful transition to the community? (e.g. Anxiety/Previous unsuccessful attempts/Social circumstances etc.)** | | |
| **Are there any risks that the individual poses when engaging with others? e.g. aggressive tendencies, known triggers, previous behaviours etc.** | | |
| **Is this individual under MAPPA/ MARAC? If yes, please include category and level:**   |  |  |  | | --- | --- | --- | | Yes ☐ | **Category** |  | | No ​☐​ | **Level** |  | | | |
| **Which other agencies are involved in this person’s care?** | | |
| **Offender Manager in Custody details (if applicable):** | | |
| **Probation Officer and contact details (if applicable):** | | |
| **Details of Referrer** | | |
| **Name:** | | |
| **Job Role: (if staff member)** | **Contact Number:** |  |
| **Email Address:** | | |

Thank you for completing the referral form.

Please ensure **ALL** areas of the form are completed, consent has been obtained, and the requested required documents are attached to your referral email, as these are required to process your referral.

Please send your referral to:  [dhcft.derbyshirereconnect@nhs.net](mailto:dhcft.derbyshirereconnect@nhs.net)

Should you have any queries please do not hesitate to contact the team should you wish to discuss your referral on: 01332 389190

**We aim to respond to your referral within number of 5 working days.**