|  |  |
| --- | --- |
| Date |  |

**Access Mind BLMK’s Services**

**DBT Graduate Peer Support Group**

To access our services, please complete this form and we will contact you to discuss next steps. Please provide as much information as possible.

Please note that you can only access this group once you have graduated. Therefore only submit your referral on completion of skills training.

|  |
| --- |
| Your Details |
| First Name  |  |
| Surname  |  |
| Email  |  |
| Address | Date of Birth |  |
|  | Home Tel: |  |
| Mobile Tel: |  |
| How would you like us to contact you?  |
| Home Tel: |   | Email |   |
| Mobile Tel: |   | Post |   |
| Postcode |  | Ok to leave message?  |   |

|  |  |  |
| --- | --- | --- |
|  |  | Employment Information |
| Employed  |   | Unemployed |   | Military Veteran |   | Carer |  | Education |   |

Please confirm that you have the consent of the person for Mind BLMK to contact them in an emergency by ticking the checkbox below.

My emergency contact has given their consent:

|  |
| --- |
| Emergency Contact |
| Name  |  |
| Tel No: |  | Relationship  |  |

|  |
| --- |
| GP Details (if known) |
| Name  |  |
| GP Address  |
|  |
| Postcode |  | GP Tel: |  |

|  |
| --- |
| If you are a health or social care professional helping a person to access our services please attach a risk assessment and/or care plan. This is a requirement. |

Risk assessment/care plan attached:

|  |
| --- |
| Details of referrer (if completing the form on behalf of someone) |
| Name of referrer |  |
| Organisation Address  |  |
|  |
| Email |  |
| Tel: |  |

**If you can fill in the rest of this form please do so. Alternatively you can sign and return this form to the address overleaf and we will contact you for further information.**

|  |
| --- |
| Please provide the following information:  |
| Where did you attend DBT Skills Training? | Dates of DBT Skills TrainingStart:Finish: |

|  |
| --- |
| Please make sure that you have printed out our DBT Graduate Support Group Contract as well. You must sign this agreement before accessing the group. |
|  |

|  |
| --- |
| We require that all members of the group have an up-to-date personal safety plan. If you require any support with updating this please download the guidance sheet from our website as well.  |
|  |
| Data Protection (Please complete if **you** are the person accessing our services) |
| Mind BLMK adheres to the Data Protection Act 1998’s principles of good information handling and the EU General Data Protection Regulation 2018. Information will be:* Fairly and lawfully processed
* Processed for limited purposes
* Adequate, relevant and not excessive
* Accurate and up-to-date, not kept for longer than necessary and secure.

**Your agreement**I, (print name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby give permission to Mind BLMK to process my information in line with the Data Protection Act 1988 and the EU General Data Protection Regulation 2018. I agree that information can be both sought and shared with Mind BLMK about my health and welfare and that such information will be securely stored, both on paper and electronically.Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_ **Please note**: If submitting this form electronically you will be asked to sign and date a printed copy at your first meeting. |

|  |
| --- |
| **OFFICE USE ONLY** |
| Outcome |  | Date  |  |

**Please return this form marked ‘Private and Confidential’ to:**Mind BLMK, The Rufus Centre, Steppingley Road, Flitwick MK45 1AH or email: hq@mind-blmk.org.uk Tel: **0300 330 0648** Fax: **01525 722224**



**Mind BLMK**

**Equal Opportunities and Disability Monitoring**

**We aim to provide equal opportunities and fair treatment for everyone. We would like you to complete this form in order to help us understand who we are reaching and to better serve the community. All details will be treated as confidential and are held in accordance with the Data Protection Act 1998 and the EU General Data Protection Regulation 2018.**

|  |
| --- |
| **Name:** |
| **Age group:** | **Gender:** | **Sexual orientation:** | **Religion/Faith:** |
| 17 or under 18-29 30-39 40-49 50-59 60-69 70 and over Prefer not to say  | Male Female The gender ticked above is different from the sex assigned to me at birth Prefer not to say  | Bisexual Gay man Lesbian Heterosexual Other *Please specify:*Prefer not to say  | No religion/faith Christian (anydenomination) Buddhist Hindu Sikh Muslim Jewish Other *Please specify:*Prefer not to say  |
| **Disability:** | **Ethnicity:** |
| **Are your day-to-day activities limited because of a health problem or disability which has lasted or****is expected to last for at least****12 months?**No Yes, limited a lot Yes, limited a little Prefer not to say *If yes, please specify briefly:* | **White** English / Welsh / Scottish /Northern Irish /British **White** Irish **White** Gypsy or Irish Traveller \*Any other white background **Mixed** White and Black Caribbean **Mixed** White and Black African **Mixed** White and Asian \*Any other mixed background **Black** or British African **Black** or British Caribbean \*Any other black background **Asian** or British Indian **Asian** or British Pakistani **Asian** or British Bangladeshi **Asian** or British Chinese \*Any other Asian background *\*Please specify:* Prefer not to say  |

**Thank you for completing this form**