Referral Criteria

Referrals will be considered from all clinicians and mental health professionals.

Well-come is a referral-only, volunteer-led, grant-funded support group serving adults with mental health issues in the Dereham area.

Typical twice weekly sessions include crafts, games and cooking etc. We have been running in Dereham since 2004.

Age Limits: The age limits for referral acceptance are 18 and over.

Diagnosis: Client must have a severe and enduring mental illness.

Lack of Community Support: Priority will be given to those who either live alone or have little or no contact with other non-statutory agencies.

Risk: We ask referrers to give consideration as to whether the prospective client may be suitable for a group run by community volunteers.

For example, do their symptoms and behaviours pose a risk to themselves, the other clients or volunteers. If applicable please state on the referral form. We will still consider them, but there might be a need for a joint risk assessment.

Ability to benefit from the Centre: Those referred must be willing and have enough commitment to attend and participate in the activities of the group (although we understand this may fluctuate due to their mental/physical health).

For maximum benefit it is expected that the referred attends the group for at least one session each week, and communicate reasons for any absence.

Drug and Alcohol Abuse: We will not give access to the sessions to anyone under the influence of alcohol or illicit drugs.

Acceptance: On receipt of a completed referral form, the Well-come Team Leader will make an assessment to accept or refuse the application to join the group.

Return all documentation to:

The Team Leader
Well-come
Wellspring Family Centre,
35 Neatherd Road,
Dereham, NR19 2AE.

Well-come Group Referral Form
(confidential when completed)

Client Details

Name: ....

Also known as: ....

Title (Mr, Mrs, Miss, Ms, other): ....

Date of Birth: ....

Live alone/Residential/other: ....

If other, please state: ....

Ethnicity: ....

Address: ....

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Tel No: ....

Religion: ....

Support System

Consultant: ....

Based at: ....

Tel no: ....

CPN: ....

Based at: ....

Tel no: ....

GP: ....

Based at: ....

Tel no: ....

SW: ....

Based at: ....

Tel no: ....

Support Worker: ....

Based at: ....

Tel no: ....

Next of Kin: ....

Tel no: ....

Carer: ....

Tel no: ....

PLEASE INCLUDE MOBILE TEL. NOS.

Medical Referral

Write below details of any specific aims or goals there are for this client and how you feel these may be met by attendance at the group. We are particularly interested in knowing about any previous treatments that have or have not helped. If there is any way in which you feel we could work in conjunction with other agencies that will ultimately be of benefit to the client please let us know.

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Please indicate if the client has any particular interests or hobbies.

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What is the main diagnosis?

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Does the client have any other relevant physical/neurological diagnoses? (i.e. Diabetes, Epilepsy)

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Is the client on any medication?

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Does the client have any behaviours that we should be aware of? (i.e. risky behaviour such as self-harm)

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Referral Agency

Signature of Referrer: ....Please Print Name: ....

Designation: ....Based at: ....

Contact Tel No: ....e-mail address.....................................

All personal data will be stored and used in accordance with our GDPR policy, copy available on request