ASSESSMENT FORM

Blessings Care Group
In Partnership with Blessings Care Ltd

Basic Information

Service User's Name:	**Date of birth**:	**Gender**:
Phone No:		

Mental Health Needs: please list inclusive of diagnosis and medications:			
NHS Number:			
Mental illness/mental health needs:			
Please list diagnosis and medications: Due to be registered blind Walking in A& E			
Are they entitled to 117 after care? (please ask them)			
Level of support required: (please tick where appropriate)	High	Medium	Low

Prescription medication? Please provide full list of all medications and state what they are for including dosage: Use a separate sheet to include all medication.

Medication:	**Dosage**	**Reason**	**Duration taken**
		Depression	**ongoing**

Mental Capacity:	
Is there Mental Capacity issues?	*supply further information including frequency, triggers, last episode*
Has a Mental Capacity Test	*supply further information including who completed Test and date*
	supply further information including and triggers

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SUCIDE: (if Care Coordinator or Social Worker involved they will have information)	
Suicidal ideation	*supply further information including frequency, triggers, last episode*
Attempts to end life?	*supply further information including frequency, triggers, last episode*
Significant dates that can trigger relapse in mental state.	*supply further information including and triggers*
Self-Harming Behaviours: (if Care Coordinator or Social worker involved, they will have information)	
Have they ever deliberately self-harmed?	*supply further information including frequency, triggers, last episode*
How do they self-harm?	*supply further information including frequency, triggers, last episode*
Self-harming method?	*supply further information including frequency, triggers, last episode*
Self-harming Triggers?	*supply further information including frequency, last episode*
Has this led to hospitalisation?	*supply further information including frequency, triggers, last episode*
Date of Last Episode:	*supply further information including frequency, triggers, last episode*

Physical Health needs and please list and diagnosis and medications:	
Drug misuse:	Alcohol:
Criminal behaviour:	Violence:
Illness:	Disability:

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Gambling	Other
Professional Support Network: Please give details of any other agencies or supportive organisations involved, including names and contact details	
5. Former GP - Dates	6. Former GP - Dates
Criminal convictions? Please list ALL convictions with dates:	
Have they ever been under any form of supervision? Please tick relevant box:	
[ ] Probation [ ] Suspended sentence [ ] Supervision order [ ] Parole [ ] Care order [ ] Care programme	
Are they in custody? Please give details:	
Release date:	
Applicant Statement:	

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For the reason, they need supported housing:
Imagine: *What do they imagine in their future?*
Believe: *What do they believe they can achieve with this opportunity?*
Achieve: *What would they like to achieve for themselves?*
Section 3: Risk Assessment
Statement from Referring agency:
Please state how long you have known/worked with the applicant?
What capacity have you known the applicant?
Please provide details of any restrictions or orders placed on the person? Such as Tag, or Community Treatment Order (CTO), S37/41 Ministry of Justice. (MOJ).
Details of any restriction orders placed on the applicant, tick box and provide detail: [ ] Tag [ ] Community Treatment Order (CTO [ ] S37/41 Ministry of Justice (MOJ) [ ] Other [ ] Care
Are they open to secondary mental health services and please give information on past assessments/treatments and history to include length involvement and any Hospital admissions?
Please provide a brief risk assessment and rating in respect of risk posed to self/others:

[ ] High	**[ ] Medium**	**[ ] Low**		Explanation:

Please provide a copy of risk assessment and care plan:
Financial: What funding and support is available to them? Such as: 117 Aftercare provision

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By signing and/or submitting this form you agree that you have given accurate information. Note that we may be unable to accept your application if any of this information turns out to be false which may lead to complaint to your agency.

Signed Applicant :

Signed Referring Agency:
Name:
Job Title:
Tel:
Email:

Date:

Please add any additional information here and email to

referral@blessingscarehome.co.uk

Blessings Care Group Assessment Outcome

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