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| **Referral Type:** Self-referral (preferred route)  Professional referral |

# Text Description automatically generated with medium confidence

# SERVICE USER NETWORK (SUN) MEMBERSHIP REQUEST FORM

# Member Details

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| **Title** | Mr  Mrs  Miss  Ms  Mx  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **First Name** |  |
| **Last Name** |  |
| **Pronouns** | She/Her  He/Him  They/Them  Other  ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Address** |  |
| **Postcode** |  |
| **Telephone Number** |  |
| **Email Address** |  |
| **NHS Number (if known)** | <https://www.nhs.uk/nhs-services/online-services/find-nhs-number/> |
| **Date of Birth (dd/mm/yyyy)** |  |
| **Ethnicity** | **Asian or Asian British**  Indian   Pakistani  Bangladeshi  Chinese  Any other Asian background  **Black, Black British, Caribbean or African**  Caribbean  African  Any other Black, Black British, or Caribbean background  **Mixed or multiple ethnic groups**  White and Black Caribbean  White and Black African  White and Asian  Any other mixed or multiple ethnic background  **White**  English, Welsh, Scottish, Northern Irish or British  Irish  Gypsy or Irish Traveller  Roma  Any other White background  **Other ethnic groups**  Arab  Any other White background  Prefer not to say |
| **Gender** | Man/Male  Woman/Female  Non-binary  Prefer not to say  Other ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **GP Practice Name** |  |
| **Address**  **Postcode** |  |
| **Phone number** |  |
| Do you have any medical conditions we may need to know about in an emergency (e.g. epilepsy, diabetes, allergies or asthma)? | Yes  No  If yes, please give details:\_\_\_\_ |

# GP Practice

# Current Mental Health Difficulties

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| **Have you been given any diagnosis for your mental health difficulties?**  Yes No  If yes, please list below:    **Are you currently on a waiting list for therapy?**  Yes No  If yes, please specify which service/team you are awaiting therapy with:    **Do you experience any of the following difficulties (please tick all that apply):**  Intense/rapidly changing emotions  Frequent episodes of intense anger  Difficulties in forming/maintaining relationships  Impulsive risky behaviour  Low self-esteem/poor sense of identity  General mistrust/suspicion of other people  Other (please give brief details) **:\_\_\_\_\_         Please answer the following questions as honestly as you can based on how you generally are as a person. In general (in most situations):**  Do you have difficulty making & keeping friends YES  NO  Would you normally describe yourself as a loner YES  NO  In general, do you have difficulties trusting other people YES  NO  Do you normally lose your temper easily YES  NO  Are you normally an impulsive sort of person YES  NO  Are you normally a worrier YES  NO  In general, are you a perfectionist YES  NO  In general, do you depend on others a lot. YES  NO  **Please select any of the following that apply to you:**  Autism / Autistic Spectrum Disorder/Condition (ASD/ASC)  Learning Disability (by this we mean reduced intellectual ability/reduced ability to learn new things. You **don’t** need to tick this box if you have a learning difficulty e.g. dyslexia, dyspraxia).  Traumatic Brain Injury  Dementia  Alcohol consumption above recommended guideline of 14 units/week  Use of illegal drugs and/or non-prescribed prescription medication.  Open to a probation service  In the last year, been arrested/charged by the police  **Please give further details on the nature/severity/how this affects you** :\_\_\_\_  *A member of the SUN team may discuss these further with you before signing you up to your first group. This is to establish what impact (if any) the above may have on the suitability of SUN groups in supporting your needs.*  **Do you have any accessibility needs that it would be helpful for SUN to be aware of?**  (e.g. if you are Deaf/hard of hearing, blind/visually impaired, if you have a physical disability, have difficulty with written information, or difficulty accessing technology like emails)  **Please let us know what access or support you need** :\_\_\_\_ |

# Emergency Contact Details

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| *If you have someone that can be contacted in an emergency, please provide their details below.* | |
| **Emergency Contact Name** |  |
| **Relationship**  (i.e Partner/friend/daughter) |  |
| **Telephone Number** |  |

# How you found out about SUN

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| **How did you find out about SUN? (optional if you want to tell us)**  Found the website/leaflet myself  GP / Mental Health Practitioner in GP surgery  Crisis Team  CMHT  Complex Needs Service (CNS)  PIRLS (Psychiatric Inreach Liaison team in A&E)  Through a friend  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Group participation agreementTerms of MembershipI understand that by joining SUN:  * I am agreeing to participate in a support group where I will share information about myself, some of which may be sensitive or personal, with professionals and other members. * I am agreeing to respect the confidentiality of other group members who will also be sharing information about themselves, some of which may be sensitive or personal. * I am agreeing to remain respectful within the group setting, and I understand that any behaviour felt to be unsupportive will be addressed within the group. **Please familiarise yourself with the SUN group agreements provided in your welcome pack before attending your first group.** * I am agreeing that the SUN team can contact me via email and phone. * I understand that professional visitors may at times observe groups or other aspects of the service. I understand that these visitors will not have access to my details on the system, but that they may hear information about me during their visit. I understand that they will need to keep anything they hear confidential.   **Information sharing**   * I understand SUN will only get in touch with the person who is named as the emergency contact on my membership form if I am unable to do so. For example, in the case of a medical emergency. I understand SUN will only provide this contact with the information needed to support me. * I understand SUN may share information with other professionals or services under certain circumstances when there is a concern about my safety or the safety of someone else. I understand that while this will usually be discussed with me beforehand, information may need to be shared without my agreement.   **Data Protection**   * I understand my personal details and information about my attendance at groups will be stored on a secure system. * I understand that if I wish to end my SUN membership, I will need to contact the team to request this. * I understand that invitations for virtual groups will be sent in a manner that does not make my email address visible to other group members. * I understand that if I choose to use my full name on my Teams account or share any personal contact details with other group members, this is my own responsibility.   **Service Evaluation and Feedback**   * I understand SUN will send me regular outcome measures/feedback surveys as part of service evaluation. I understand that I can opt out of this by informing the SUN administrator. |

**I have read and agree to the above membership conditions**

**Please return your completed membership form to:**

[**BucksSUN@oxfordhealth.nhs.uk**](mailto:BucksSUN@oxfordhealth.nhs.uk) **or**

**By post to: Bucks SUN, Psychological Services, The Whiteleaf Centre, Bierton Rd, Aylesbury HP20 1EG**

*If you require support completing this form or would like to request an alternative format or language, please contact the team on 01865 901900 or using the email above.*