Mayfield Nurseries
Gardening for better mental health

Mayfield Nurseries Physical Health Project Referral and Risk Assessment Form

SOUTHAMPTON CITY COUNCIL

Name	Address	Date of birth
Home Phone number Mobile Phone number can we leave a message? yes/no	email address	Preferred method of contact phone call email text
Gender male female other prefer not to say	Emergency contact details name email/phone	GP Surgery GP name
Do you receive support from any other services? If yes please give details. Name of service Keyworker name Keyworker contact details	Disabilities (please circle all that apply) None Mobility Learning Visual Hearing Other	
Current Mental health concerns	Current physical health concerns	Are you aware of and/or attend an annual physical health check?

Please circle any areas of interest below, this will help us support you achieve your personal goals.

Gardening/Horticulture

Nature

Walking

Peer support

Recycling/sustainability

The environment

Anything else ? Please give details

Please us this box to share any other relevant information about yourself. for example, if you need support to access the service or any personal goals that you may have ,

Risk Assessment

Please answer all of the following questions and insert n/a to those that do not apply

	Current - within the last 6 months?	Past issue please provide dates	Further relevant information- please describe
Do you have a mental health diagnosis ?			
Have you ever experienced suicidal thoughts and feelings? Do you currently think about plans for acting on these thoughts and feelings? Have you ever acted on suicidal thoughts and feelings?			
Have you ever self harmed in any way? e.g. cutting, burning , other			
Have you ever experienced difficulties with drugs or alcohol?			
Do you have any criminal convictions?			
Have you ever had feelings of the intention to harm others? Have you ever acted on these feelings? e.g. violence or verbal abuse Do you experience episodes of anger and or frustration?			
Do you have support from social services for yourself or for children that you might live with?			

	Current- within the last 6 months?	Past issue please provide dates	Further relevant information - please describe
Have you ever experienced verbal, physical or any other form of abuse? Do you feel vulnerable in the company of any other person that you might know?			
Do you difficulties maintaining your personal hygeine and/ or eating and drinking ?			
Do you require support with your mobility?			
Do you have any allergies? If you carry an EpiPen please ensure you carry this with you when taking part in activities at Mayfield.			
Do you take medication that you may be required to take whilst taking activities at Mayfield? Lockers are available on site to safely store medication which will be your personal responsibility at all times.			

Declaration of consent

please tick to confirm consent

I am aware of this referral to Mayfield nurseries . ☐

I consent to my personal information included on this form to be shared with Mayfield Nurseries wellbeing staff. ☐

I consent for Mayfield Nurseries wellbeing staff to contact my GP and/or care coordinator to share relevant personal information. ☐

Name.....

signed.....

date.....

Employment Information

Please circle all that are applicable

In fulltime/part time education	self employed
employed 40+ hours/week	employed 1-39 hours/week
not employed and looking for work	not employed and looking for work
retired	disabled/medically unfit for work
carer	diagnosis on the autism (ASD) spectrum

Ethnicity

please circle the correct information

Asian or Asian British

Black, Black British, Caribbean or African

Mixed or multiple ethnic groups

White

Other ethnic group

Name of person completing this form.....

signed.....

email.....telephone.....

date.....

Please return the completed form to

Mayfield Nurseries Wellbeing Team,
Mayfield Park, Weston Lane, Southampton SO199HL
email: enquiries@mayfieldnurseries .org.uk

Staff use only	**date referral received**
date of first contact **staff name**	**date of second contact** **staff name**
date of assessment booking **time** **staff name**	**Care coordinator informed if unable to contact service user** **yes/no email/telephone** **staff name** **date**