Ashford Place

Mental Health Mentoring Project

CLIENT REGISTRATION FORM

Title	Mr	Ms	Miss	Mrs	Dr	Prof
First Name						
Last Name						
Telephone No						
Mobile No			Permission to text	Yes	No	
Email Address						
Sign up for our newsletter	Yes	No				
National Insurance No						
Address Postcode						

Referral Type: Please Select					
Statutory	☐	Self		Voluntary	
Name of Referral Organisation					
Name of the Person making the Referral					
Contact Details: Telephone No./ Mobile: Email:					
Referral Notes - **Please provide a short summary of why the client is being referred**					

Is the client a Brent resident?	Yes ☐ No ☐
Date of referral to Brent Peer Services	
NHS Number:	
Name & Address of GP Practice Telephone No.	
GP Practice code:	

RISK

Type of Risk	
☐ Under current safeguarding plan	☐ To children
☐ Self Neglect	☐ To staff
☐ Self harm	☐ Non - Compliance of medication
☐ Suicide	☐ Mental Illness
☐ Abuse by others	☐ Falls
☐ Abuse to others	☐ Other
Please give further details and advise if CURRENT or PAST risk:	

DEMOGRAPHICS

Gender:		Birthdate:	
Nationality:		First Language:	

Marital Status:							
Single	☐	Divorced	☐	In a couple	☐	Not Known	☐
Married	☐	Separated	☐	Other Relationship	☐		

Ethnic Origin					
Asian or Asian British – Bangladeshi	☐	Black or Black British - African	☐	Mixed – Other	☐
Asian or Asian British – Pakistani	☐	Black or Black British – Caribbean	☐	White – British	☐
Asian or Asian British – Indian	☐	Black or Black British – Other	☐	White – Irish	☐
Asian or Asian British – Other	☐	Mixed – Asian & White	☐	White – Other	☐
Chinese	☐	Mixed – Black African & White	☐	Other Ethnicity	☐
Gypsy / Romany / Irish Traveller	☐	Mixed – Black Caribbean & White	☐	Prefer not to say	☐

Sexual Orientation					
Bisexual	☐	Lesbian	☐	Other	☐
Gay	☐	Heterosexual	☐	Prefer not to say	☐

Religion							
Buddhism	☐	Islam	☐	Non-Believer	☐	Zoroastrianism	☐
Christianity	☐	Jainism	☐	Rastafarian	☐	Other	☐
Hinduism	☐	Judaism	☐	Sikhism	☐	Prefer not to say	☐

IN CASE OF EMERGENCY

Name of Contact		Relationship to you	
Contact Number			

DISABILITY & LEARNING DIFFICULTIES

Disabilities					
Visual Impairment	☐	Hearing Impairment	☐	Profound Complex	☐
Temporary Disability after Illness	☐	Mental Health	☐	Other Disability	☐
Disability Affecting Mobility	☐	Multiple Disabilities	☐	Other Medical	☐
Emotional/Behavioural disability	☐	Rheumatoid Arthritis	☐	None	☐
Learning Difficulties					
Moderate Learning Difficulty	☐	Multiple Learning Difficulties	☐	Dyscalculia	☐
Severe Learning Difficulty	☐	Other Learning Difficulty	☐	Dyslexia	

To the best of my knowledge, the personal details on this form are accurate and complete. I note that these details will be processed by Ashford Place under the principle of the 2016 General Data Protection Regulation **GDPR**. I understand that Ashford Place is required to provide my personal information for statistical purposes to Ashford Place contracted funders. This data will be retained while I am an active client and 24 months thereafter.

Client Signature		**Date**	

For more information on how and why we store data please see our transparency notice on the Ashford Place website: www.ashfordplace.org.uk/about-us/summary-transparency-notice

Once completed, please email this form to: tania.town@ashfordplace.org.uk
or post to:
Ashford Place | 60 Ashford Road | London | NW2 6TU