RECONNECT
Care in custody – Care after custody

NHS

Berkshire Healthcare
NHS Foundation Trust

RECONNECT Professional Referral Form

Referrals will be accepted for any person aged 18 or above leaving a secure or detained setting (prison/IRC/CYPSE) with an identified health need which means that they would otherwise struggle to engage with community-based healthcare services and/or relevant support services.

RECONNECT offers liaison, advocacy, signposting, and support to facilitate engagement with community-based health and support services. RECONNECT will not duplicate other service provisions of support.

RECONNECT will only accept referrals where consent is given by the referred individual. Full risk assessments should also be provided.

Should you have any queries please do not hesitate to contact the RECONNECT team.

RECONNECT Referral Form	
Date of referral:	
Name of individual being referred: **Preferred name:** **Aliases / other names know by:**	
Referring service: Other **Please state service name and location** (where possible please provide prison code)**:** **If 'Other' was selected, please provide details, and confirm the name of the referral below:**	
Prison Number: **NHS number if known:**	**Date of Birth:**
Please confirm the individual is aware of the referral and sharing of information. (Please ensure the consent to share information form has been signed by the individual and is included with this referral) ☐ **Yes, consented to referral and RECONNECT to accessing healthcare and other professional records.**	
What is the individual's sex? Prefer not to say	**Is the gender the individual identifies with the same as their sex registered at birth?** Prefer not to sa
Religion or belief: Not known (not recorded)	**Ethnicity:** . Not known (not recorded)
Sexual Orientation: Not known (not recorded)	**Marital Status:** Not known (not recorded)
Pregnancy and Maternity: Prefer not to say	**What is the individuals preferred pronouns?** (i.e. he/him, she/her, they/them)
Armed Service history (including reservist)**:** Not known **If yes, have/are they engaged with a veteran's specific service** (i.e. Op NOVA, Veterans HQ, HMPPS ViSCO's etc.)**? If so, please provide details:**	

Area the individual will be released to and are they familiar with this locality:
Home Address: Please indicate if no fixed abode upon release – where there is no fixed abode does the individual have known areas where they can be located, if so please provide details.
Family/ Personal Circumstances (e.g. will this person have family support on release, will they live with family? Support of friends etc.)
Does the individual consent to a next of kin/trusted person being contacted, if there are difficulties in making direct contact with the individual? (If yes, please provide name and contact details of next of kin?)
Does the individual have any caring responsibilities? (i.e. children, main carer for family member. Responsibilities including health and social care, financial care, support with shopping etc.)
Identified health and wellbeing needs – diagnosed or suspected (e.g. Neurodiverse conditions i.e. ADHD, Acquired Brain Injury, Autism, dyslexia; physical disabilities, mental health conditions, substance misuse needs – alcohol and/or substances; social/behavioural needs, sensory needs)
Where needs are identified please describe current or historic support received:
Where needs are identified please state which of these (and any other barriers to engagement) require RECONNECT support for ongoing health engagement/access to treatment/support?
Does the individual require any reasonable adjustments?
Is the individual registered with a GP? If yes, please state which GP.
Does this individual have a health passport? If so, please attach to this referral form:
Does the individual have any current or historical risk to self (self-harm/suicide/accidental harm to self), including alerts/ACCT status? If so, please provide details (i.e. OaSYS risk score**):**
Release date/ROTL dates if known:

Please provide any relevant details regarding the individuals current offence, including if the individual subject to any license conditions (e.g. geographical tag/curfew etc.)**, length of sentence etc.:**
Does this individual have any restraining orders? If so, please provide details:
Are there any concerns about a successful transition to the community? (e.g. Anxiety/Previous unsuccessful attempts/Social circumstances etc.)
Are there any current/historic risks that the individual poses when engaging with others? e.g. nature of offending, **aggressive tendencies, known triggers, previous behaviours etc. Please specify current risk level if known from professional formulations** (i.e. OaSYS, healthcare systems, NDeluis ect.)
Is this individual under MAPPA/ MARAC? If yes, please include category and level:

Yes ◯	**Category**	
No ◯	**Level**	

Which other agencies are involved in this person's care? Please provide contact details:		
Offender Manager in Custody details (if applicable)**:**		
Probation Officer and contact details (if applicable)**:**		
Details of Referrer		
Name:		
Job Role: (if staff member)	**Contact Number:**	
Email Address:		

Please tick to confirm a risk assessment is attached to this referral ☐

Thank you for completing the referral form.

Please ensure **ALL** areas of the form are completed, consent has been obtained, and the requested required documents are attached to your referral email, as these are required to process your referral.

Please email your referral form to:

Thames Valley – ReconnectReferrals@berkshire.nhs.uk

Hampshire – ReconnectReferralsHampshire@berkshire.nhs.uk

To discuss your referral or speak to the team, please call –

Thames Valley – 0300 365 555

Hampshire – 0300 123 5066

We aim to respond to your referral within 7 working days