

INITIAL REFERRAL FOR MENTORING



Please complete this application in Word and return as attached document by secure email. Please note not all referrals can or will be accepted. We would like a discussion about why this client would benefit from support by a CCN mentor.

This initial referral request is coming from: (place X in box)

| | |
|--------------------------|-------------------|
| <input type="checkbox"/> | Chaplaincy team |
| <input type="checkbox"/> | Resettlement team |
| <input type="checkbox"/> | Other - |

| | |
|--------------------------|-----------------------|
| <input type="checkbox"/> | Probation / CRC |
| <input type="checkbox"/> | Accommodation manager |

| | | |
|--|--------|------------|
| Name of prison, accommodation or NPS / CRC: | | |
| Name of referrer: | | |
| Contact details | Email: | Telephone: |
| Prison Offender Manager (name & Email address) | | |

| | | | | | |
|--------------------|--|------------------------------------|--|-------------|--|
| Name of individual | | Ethnicity | | Gender | |
| Prison Number | | Wing | | Cell number | |
| Date of birth | | Client phone no. (if in community) | | | |

| | | | |
|--------------------------------|--|--|--|
| Release date (past or pending) | | Is individual aware of this referral? Y/ N | |
|--------------------------------|--|--|--|

Choose one for each box: Y = yes (explain) N = no U = unknown Explain 'Y' boxes below.

| | |
|--------------------------|--------------------------------|
| <input type="checkbox"/> | History of violent offences |
| <input type="checkbox"/> | History of sexual offences |
| <input type="checkbox"/> | MAPPA designated |
| <input type="checkbox"/> | Accommodation issues (explain) |

| | |
|--------------------------|-------------------------------------|
| <input type="checkbox"/> | Considered vulnerable (explain) |
| <input type="checkbox"/> | Considered 'high risk' (explain) |
| <input type="checkbox"/> | Substance addiction (explain) |
| <input type="checkbox"/> | Other significant factors (explain) |

| |
|---|
| Explanations: (Expand box as necessary) |
|---|

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|--|
| Accommodation plans / situation: (Expand box as necessary) |
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| | |
|------------------|--|
| Date of referral | |
|------------------|--|

Thank you for making this referral to Community Chaplaincy Norfolk (CCN). We will endeavour to reply as promptly as possible. If we have the capacity to accept this individual for mentoring we will advise you

Please send this Initial Referral form to: melanie.wheeler@ccn.cjsm.net

