Referral form

From health professional

Please indicate which services will be required (please tick)

Recovery coach project	☐	**Telephone Befriending scheme**	☐
Men's peer support	☐	**Women's peer support**	☐
Peer support Evening Social	☐	**Peer Support**	☐

Self help courses (Please state which course you are interested in)

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1. Name of person being referred		**Date of referral**	
Address			
Contact details	**Home telephone:** **Mobile telephone:** **Email:**		
Date of Birth			
Next of Kin name, relationship and contact details			
Employment status (please tick)	**Employed**	**Un-employed**	**Self Employed**
2. Name of Referrer (if not self referred)			
Referring organisation/ address			
Position/team			
Contact details	**Office telephone:** **Mobile telephone:** **Email:**		
<u>GP Details</u> **Name:** **Address:** **Contact Number:**			

3. Current situation and social circumstances, including whether the person lives alone, relationships with carer/family, accommodation etc.

Yes		**No**	

5. Carer Identified (please tick).

If yes, please provide details below.

4. Nature of mental health issues: Please indicate diagnosis, admissions to hospital and current level of functioning.

5. Safeguarding issues: Please indicate any safeguarding issues based on received information, past history and your knowledge.

Risk		**Yes**	**No**	**Comment**
Risk To Self	Self-neglect			
	Self-harm			
	Suicide attempt			
	Drug/ alcohol misuse			
	Isolation			
Risk/ Abuse From Others	Physical			
	Financial			
	Sexual			
	Other			
Risk To Others	Violence toward family/ friends			
	Violence toward the public			
	Safe to visit alone?			
Risk To Property	Damage to property			
	Theft			
	Other			
Homelessness				
Other				

6. Please detail any allergies, physical health problems (such as back pain, diabetes, epilepsy), learning disabilities or other support needs, or medication we should be aware of:

Has consent been given by the client for this information to be shared: yes/ no (please circle).

Referrers name:_____

Signed: _____

Date:_____

Person referred name _____

Signature _____

Date:_____

Assessment carried out by: (for office use only)

_____

Date: _____

Thank you for completing this form. The information supplied will be kept in the strictest confidence and in accordance with Central Notts MIND's data protection policies. Please return the form to:

The referral department,
Central Notts Mind
14 St Johns Street
Mansfield
Notts
NG18 1QJ
referrals@centralnottsmind.org

After receiving the referral form we will contact you within approximately 14 days.