

## Referral form

### Self Referral

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 below which course you are interested in)

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<b>1. Name of person being referred</b>		<b>Date of referral</b>	
<b>Address</b>			
<b>Contact details</b>	Home telephone: Mobile telephone: Email:		
<b>Date of Birth</b>			
<b>Next of Kin name, relationship and contact details</b>			
<b>Employment status (please tick)</b>	<b>Employed</b>	<b>Un-employed</b>	<b>Self Employed</b>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>GP Details</b> Name: Address: Contact Number:			

**2. Current situation and social circumstances**, including whether you live alone, relationships with carer/family, accommodation etc.

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

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

<b>Risk</b>	<b>Yes</b>	<b>No</b>	<b>Comment</b>
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			

**5. 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:**

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6.

	<u>Name</u>	<u>Contact details</u>
Psychiatrist		
CPN		
Social Worker		
Other		

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

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](mailto:referrals@centralnottsmind.org)

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

To provide the best quality of care, it is sometimes necessary to contact other agencies.