

Referral form

From health professional

Please indicate which services will be required (please tick)

Recovery coach project	<input type="checkbox"/>	Telephone Befriending scheme	<input type="checkbox"/>
Men's peer support	<input type="checkbox"/>	Women's peer support	<input type="checkbox"/>
Peer support Evening Social	<input type="checkbox"/>	Peer Support	<input type="checkbox"/>

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:			
GP Details Name: Address: Contact Number:				

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

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Yes		No	
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5. Carer Identified (please tick).
If yes, please provide details below.

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

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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 _____

Signed: _____

Date: _____

Assessment carried out by: (for office use only)

Date: _____

Please confirm that we can contact you via the following:

Text Phone Email Post

Your data will be sorted in line with the new GDPR guidelines and Minds policies and procedures.

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.