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| **REFERRAL FORM** | | | | |
| **Referral Completed by:** | | | **Date of referral:** | |
| **Contact Details:** (*Please provide preferred communication method to receive patient updates and information)* | | | **Profession:** | |
| **GP surgery:** | | | **PCN:**  **Hub Locality:** | |
|  | | | | |
| **PERSONAL DETAILS** | | | | |
| **Title:** | | **Forename:** | **Surname:** | **Date of birth:** |
| **Address & Postcode:** | | **Telephone:**  (Home/Mobile) | **Gender:**  Male  Female  Prefer not to say | **Interpreter required:**  Yes  No |
| **Relationship:**  Single  Married  Separated  Widowed  Divorced  Civil Partnership | **Ethnic Origin:**  White British  White-Irish  Other White  Black/Black British – Caribbean  Black/Black British – African  Black/Black British - other  Asian/Asian British Indian  Asian/Asian British Pakistani  Asian Other  Chinese  Mixed other  Other (please state): | | | |
| **Disability: Please identify Disability**  Behavioral and Emotional  Hearing  Learning Disability  Manual Dexterity  Mobile and Gross Motor ☐ Sight ☐ Speech ☐ Perception of physical danger  Personal self-care and continence  Progressive conditions and Physical Health  No Disability  Other (please state): | | | | |

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| **Background and Medical History** *(Please provide details of diagnosis, treatments, current mental health status etc.)* | | | |
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| **Which aspects of the service does the person require:**  **NB:** *Please complete all relevant sections in accordance to the support service required. Where two services are required, please complete two sections etc.* | | | |
| **Workshops and Groups**  *Workshops and groups will provide an opportunity for peer support & provide you with new self-management & coping strategies.* | **Befriending Support**  *Community supporters to local services and support to access & build social & community networks & activities in order to foster social inclusion & improve quality of life.* | **Peer Navigation Support**  *Support with benefits, housing, employment, training, education and support you to access community services and help you get involved with your community.* | **Substance Misuse Support**  *Workers from Change, Grow, Live (CGL). Support to listen to concerns, offer advice, harm reduction, referral, guidance & advocacy for people with drug & alcohol issues & help them get into treatment.* |
| **Complete Section: A** | **Complete Section: B** | **Complete Section: C** | **Complete Section: D** |
| **Section A: Workshops and Groups** | | | |
| Managing Anxiety  Anger Management  Employment/ Training Mindfulness  Confidence building  Managing Sleep  Other (please state): | | | |
| **What would the patient like to achieve?** | | | |
| **Section B: Befriending Support** | | | |
| **Hobbies and interests:**  Sports  Reading/Writing  Art/ Painting  Cooking/ Baking  Travelling  Puzzles/Games  Gardening  Community Activities  Computing/IT  Other (please state): | | | |
| **What would the patient like to achieve?** | | | |
| **Section C: Peer Navigation** | | | |
| **Support required:**  Accommodation  Employment/ Training Education  Finances/Debt  Council Tax/Benefits  Volunteering  Health Advice  Other (please state): | | | |
| **What would the patient like to achieve?** | | | |
| **Section D: Substance Misuse:** | | | |
| **Substance Used:**  Drug  Alcohol  **Route of Administration:**  Inject  Sniff  Smoke  Oral  Other (please state):  **How often is this used:**  Monthly or less  2-4 times per month  2-4 times per week  5-7 times per week  Everyday  Other (please state):  **How many Drugs/ Alcohol do you have a day**  0-2  3-4  5-6  7-9  10+  Other (please state): | | | |
| **Summary of Drug and Alcohol use:** | | | |
| **What would you the patient like to achieve?** | | | |
| **Risk Management** | | | |
| **Who does the patient live with:**  Alone  With Spouse/partner  With Family  In Residential Accommodation  Prefer not to say Other(Please state):  **Does the patient have parental responsibility for children aged under 18?**  Yes  No  Declined to answer  **Do any of the children live with the patient?**  Yes  No  Other(Please state): | | | |
| **Are there any Safeguarding concerns related to the patient?**  Yes  No  **If yes, please provide details** | | | |
| **Does the patient display any behavior which can increase risk to themselves or others?** | | | |

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| **Processing and Disclosing Data:** |
| I understand that Rethink Mental Illness may be required to provide my personal data to the public body which commissions Rethink Mental Illness services.  I confirm staff have discussed with me the circumstances when and the reasons why they may have to disclose personal data without my consent.  I am happy for Rethink Mental Illness may use my personal data, including concerning my health, to undertake evaluation and research in order to help plan and improve services.  I give consent for Rethink Mental Illness to use my personal data as explained in this form, and to share the following data with the following agencies or individuals. |
| **Has the person provided consent to be referred to Rethink Mental Illness?**  Yes  No |