OFFICE USE ONLY Date Received: RIS ID:

Applicant’s details

Mr / Mrs / Miss / Ms / Other:

Full name: Date of birth:

Current address:

Contact Tel no(s): Email address:

**Emergency Contact:**

Name: Relationship to you:

Tel. No:

Referrer’s name

Name: Contact:

Organisation: Position / Relationship:

Health related information

Primary Mental health diagnosis (please include dates):

Other mental health issues:

Other relevant health related information and/or access support needs **(please circle or underline):**

|  |  |
| --- | --- |
| Visual Impairment   | **Yes No** |
| Able To Read   | **Yes No** |
| Able to understand information provided/ mental capacity   | **Yes No** |
| Hearing Impaired | **Yes No** |

If Yes, please state requirement where relevant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eligibility criteria

Please read the Bridge eligibility criteria below before you make a referral to the service.

1. Adults over the age of 18 years
2. Have a diagnosed mental illness as a primary diagnosis.
3. Residents of the London Borough of Harrow

Diversity monitoring

Marital Status: Religion & Belief:

Ethnicity: Sexual Orientation:

Gender: Do you have any caring responsibilities? YES / NO

No. of Dependent Children: If YES, please give details

Reason for referral

Please state which groups/activities you are interested in attending from our current timetable

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Others involved in care and support

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **Address** | **Contact details** |
| Bentley House - Care-Coordinator or Psychiatrist |  |  |  |
| GP |  |  |  |
| Family or Friend\* |  |  |  |
| Others(please specify) |  |  |  |

How would you prefer us to communicate with you? (Please tick below)

Phone Letter Email

We will try to communicate with you by your preferred option but there may be times when we are unable to do so.

Referrer’s signature **(if applicable)**

Signed: Date:

Print Name:

|  |
| --- |
| Client consent |

 I consent for the information contained in this form to be shared with Rethink Mental Illness

 I have read & agree to the Bridge Groups Code of conduct

 Client’s name: Client’s signature:

 Date: