**Contact Details**

D.O.B:

Name:

Title:

Referrers name & service name

Please can you identify below whether the person has any information or communication support needs relating to a disability, impairment or sensory loss.

Mental Health

Sensory

Physical

Learning

Address:

Main Telephone No:

2nd Telephone No:

Town:

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­­

County:

Post Code:

E-Mail:

Name:

Emergency Contact Details:

­­

Telephone No:

 **Demographic Information**

Ethnicity:

Sexual Orientation:

Marital

Status:

Gender:

Religion::

Diagnosis

**Which aspects of the service does the person need? (Tick any that apply)**

Workshops & Groups

Befriending Support

Peer Navigation Support

Substance Misuse Support

 **Substance Misuse Support**

Please tell us below what substances the person currently uses? How often do they use this/them? How do they use the substances? When did they start using the substances? What support have they for this have already?

**Workshops and** **Groups**

Please tell us below what types of workshops the person is interested in?

**Befriending Support**

Please tell us below what interests / hobbies does the person have or used to have? Is there anything they want to do that they have not done before? Does the person live alone?

**Peer Navigation Support**

Does the person need an interpreter & if so what language?

Please confirm that the person is aware of this referral

**Risk and Safety Management**

* Does the person have any concerns about their own safety or feel at risk from anyone? Do you feel there are any risks associated with the person? If yes please tell us about this below.
* Is home working appropriate?
* Does the person have any dependant children, if so do they live with them and how old are they?

Please tell us below – is the person in hospital or leaving hospital? Please give further information regarding any unmet social needs that the Peer Navigation service can support with. i.e housing, support to access benefits, access to community groups/activities, training, education, volunteering, support to access health advice etc

Referral Date:

Signed:

How would you like us to make initial contact with you?

E.g Phone, Post, Text, Email.

**Preferred Method of Contact**

Please give details of any other support services you receive e.g. counselling, mental health support etc