Wiltshire Mental Health Inclusion Service
Referral Form

* = essential information for referral to be processed.

Referral Date:	

SERVICE USER DETAILS			
Full Name *	Mr/Mrs/Miss/Ms	**Marital Status**	
Current Address *	**Postcode:**		
Date of Birth *		**Gender ***	
Contact Details *	Home: Mobile: Email:		
Ethnic Origin		**Religion**	
Preferred Spoken Languages		**Interpreter required?**	Yes / No
Primary Mental Health Diagnosis / Concern * *(eg anxiety/depression, please provide full details in Current Circumstances section on page 2)*			

REFERRER DETAILS (if applicable – leave blank if a Self-Referral)			
Organisation / Agent		**Relationship to individual**	
Name			
Address			
Email Address			
Telephone Number			
Referrers Signature	Date:		
Does the individual <u>AGREE</u> to the referral? (please delete) *	YES / NO		

Preferred contact method (please tick) *	**Telephone ☐ Text ☐ Email ☐ Letter ☐**
How did you hear about the service? (eg leaflet, professional, website, etc.)	

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SERVICE USER INFORMATION (Please state)	
Current Circumstances (Please include details of current diagnosis or mental health symptoms at this time, any physical health needs, and any external factors that are currently impacting on the individual.) **Does the client have any communication / information needs relating to a disability or sensory loss?**	**Y / N** (If yes please give details)
Is there anything we need to be aware of when lone working? * (e.g. are there any concerns to self and/or others, any criminal convictions or incidents of violence we should be aware of) (If available, please attach risk assessment no older than 6 months)	
Any other relevant information (e.g. financial, addiction, housing, immigration, etc.)	
What inclusion support would the service user benefit from? * (eg in which areas do you feel support is needed – group activities; community engagement, access online etc.)	

Please tick if interested in accessing the following:	☐ Greener Health Project *(BA14 & BA15 area only)*	☐ Digital Tech Buddy Scheme

Completed form to be returned to:	
Wiltshire Mental Health Inclusion Service email: WiltsMHIS@rethink.org	Service Manager telephone: 07467 764171

(For Office Use Only)	
Name of person taking referral:	
Date	