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|  |  | **Referral Date:** |  |
| ***SERVICE USER DETAILS*****\*** = essential information for referral to be processed. |
| **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)* |  |

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| ***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 AGREE to the referral? (please delete) \*** | YES / NO |

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| **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 |

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

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