|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Referral** |  | | |
|  | | | |
| *CLIENT DETAILS* | | | |
| **Client Name** |  | | |
| **Current Address** | **Postcode** | | |
| **Date of Birth** |  | **Gender** |  |
| **Contact Numbers** | Home: Mobile:  Email: | | |
| **Ethnic Origin** |  | **Religion** |  |
| **Preferred Spoken Languages** |  | **Interpreter required?** |  |
| **Diagnosis** |  | | |
| **Medication** |  | | |
| **Is the person on a Care plan?**  **Communication: any preferred way to be contacted.** |  | | |

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| --- | --- | --- | --- |
| **Referring Agent/ Individual** |  | **Relationship to client** |  |
| **Name** |  | | |
| **Address** |  | | |
| **Telephone Number** |  | | |

Does the client **AGREE** to the referral **Y / N**

At times it may be necessary for Plymouth Community Services to work with other organisations, therefore we may be required to **share information**. Would you be willing for us to share information? **Y / N**

I consent for Rethink Mental Illness to process my personal information under the provisions of the Data Protection Act.

**Client Signature**: ............................................................... **Date**: ...............................

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| --- | --- |
| **GP Contact Details**  **(Name, address & telephone)** |  |

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| *ARE THERE ANY OTHER AGENCIES INVOLVED IN CLIENT CARE?* | | |
| Contact Name & Title (i.e. social worker / CPN / GP) | Agency Name & Address | Contact Number |
|  |  |  |
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| *BACKGROUND INFORMATION (Please state)* | |
| **Who to contact in case of an emergency** e.g. family, friend  (Please provide full name, address & telephone number) |  |
| **Background information of client**  (Please provide full details – e.g. first diagnosed, sections, etc.) |  |
| **Current situation of client**  (Please provide full details – e.g. anxiety, depression, bereavement, self-care, diet, etc.) |  |
| **Please provide details of patterns of behaviour (triggers) or problem areas which have lead to past breakdowns**  (Details required to help prevent/minimise future crises) |  |
| **Is there anything we need to be aware of when lone working?**  (Please provide risk assessment no older than 3 months)  (Please state if any concern to self and/or others) |  |
| **Any other relevant information**  (e.g. financial, housing, immigration, etc.) Any additional communication needs. |  |

**How did you hear about the Service?** (e.g. leaflet, professional, website, etc.)

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| *Completed form to be returned to:* |
| **By Post:**  Service Manager  Rethink Mental Illness  Kinterbury House  Kinterbury Street  Plymouth  PL1 2DG  (01752 251072)  **By Email:**  [PlymouthServices@rethink.org](mailto:PlymouthServices@rethink.org) |

|  |  |
| --- | --- |
| *(For Office Use Only)* | |
| **Name of person taking referral:** |  |
| **Date:** |  |
| **Form completed by:** |  |