**Gloucestershire Mental Health Support and Advice Service**

**Referral Form**

**If you need support to complete this form, please contact the team at** **glossupportandadvice@rethink.org** **and we will contact you to complete the form with you.**

*By submitting this information, you are consenting to your details being stored on our Rethink secure database which is accessible by all staff who work in the service.*

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| **1.** | **Date of referral:** |  |

\*indicates mandatory field

|  |  |  |
| --- | --- | --- |
| **2.** | **Client Name\*:** |  |
| **Date of Birth\*:**  |  |
| ***NHS Number:***  |  |
| ***Gender Identity:*** |  |
| ***Ethnic Identity:*** |  |
| ***Marital Status:******Miss, Ms, Mrs, Mr*** |  |
| ***Preferred Spoken Language/ Interpreter required?*** |  |
| ***Religion:*** |  |
| ***Sexual Orientation:*** |  |
| **Address\*:** |  |
| **E-Mail\*:**  |  |
| **Contact Telephone Number\*:** |  |
| **Mobile Telephone Number:** |  |
| **Preferred method of contact\*:** |  |

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| **3.** | **G.P. Name\*:** |  |
| **Surgery\*:** |  |

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| **4.** | **Current Mental Health diagnosis\*?** *(e.g. anxiety, depression, stress, ASC)* |
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| **5.** | **Can you tell us a bit about your Mental Health History\*?** *(Please include any support from Secondary / Primary Services and any interventions engaged in.)* |
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| **6.** | **Reason for Referral\*:** *Please be as detailed as possible in all relevant sections.)* |
| 1. **What do you hope to achieve from support with the service?**
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| 1. **What hobbies are you interested in?**
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| 1. **Are you interested in any of the following?**

**Groups** [ ] **Community Activities** [ ] **Adult Education** [ ] **Voluntary Work** [ ] **Paid Work** [ ] **Exposure Work** [ ]  |
| 1. **Are there any mobility / accessibility issues we need to be aware of? If yes, what is needed? Yes** [ ]  **No** [ ]
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| **7.** | **For SELF REFERRALS, how did you hear about our service\*?** |
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If self referring- you do not need to complete any other sections of this form.

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| **The following sections are to be completed by professionals only.**  |
| **1.** | **Referrers Name:** |  |
| **Team & Address:** |  |
| **Contact Telephone Number:** |  |
| **Contact E-mail:** |  |

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| **2.** | **How long will you continue to work with the Client?** *(please indicate with X)* |
| 4 weeks [ ]  | 8 weeks [ ]  | 12 weeks [ ]  | 12 weeks + [ ]  |
|  | **Comments** |

|  |  |
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| **12.** | **If available, please include a Current Care Plan/ Dialog scores with the referral** |

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| **13.**  | **Are you including a copy of a Risk Assessment/ Safety Plan?** *(please indicate with X)* |
| Yes [ ]  | No [ ]  |
| **If not including a risk assessment, are there any safety needs of the individual we should be aware of?** |

**Please confirm that the client has agreed to information sharing including risk and crisis plan?**

|  |  |
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| **Yes** |  [ ]   |

|  |  |
| --- | --- |
| **No** |  [ ]  If ‘No’, please call us to discuss how to proceed. |

**We the Referrer agree to update any relevant risk information and significant changes in care, including informing you when we discharge a client whilst supported by Rethink Mental Illness.**

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| **Signature of referrer:**  |  |
| **Please print name:**  |  |

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| **Please forward your completed referral to:**  |
|  |
| *glossupportandadvice@rethink.org* |