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| **REFERRAL FORM** |
| **Referral Completed by:** | **Date of referral:**  |
| **Contact Details:** (*Please provide preferred communication method to receive patient updates and information)* | **Profession:**  |
| **GP surgery:**  | **PCN:** **Hub Locality:**  |
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| **PERSONAL DETAILS** |
| **Title:** | **Forename:** | **Surname:** | **Date of birth:** |
| **Address & Postcode:** | **Telephone:**(Home/Mobile) | **Gender:**Male [ ]  Female [ ] Prefer not to say [ ]  | **Interpreter required:**Yes [ ]  No [ ]  |
| **Relationship:** Single [ ] Married [ ] Separated [ ] Widowed [ ] Divorced [ ] Civil Partnership [ ]  | **Ethnic Origin:**White British [ ]  White-Irish [ ]  Other White [ ]  Black/Black British – Caribbean [ ]  Black/Black British – African [ ]  Black/Black British - other [ ]  Asian/Asian British Indian [ ]  Asian/Asian British Pakistani [ ]  Asian Other [ ]  Chinese [ ]  Mixed other [ ]  Other (please state): |
| **Disability: Please identify Disability**Behavioral and Emotional [ ]  Hearing [ ]  Learning Disability [ ]  Manual Dexterity [ ]  Mobile and Gross Motor ☐ Sight ☐ Speech ☐ Perception of physical danger [ ]  Personal self-care and continence [ ]  Progressive conditions and Physical Health [ ]   No Disability [ ]  Other (please state):  |

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| **Background and Medical History** *(Please provide details of diagnosis, treatments, current mental health status etc.)* |
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| **Which aspects of the service does the person require:** **NB:** *Please complete all relevant sections in accordance to the support service required. Where two services are required, please complete two sections etc.* |
| **Workshops and Groups** [ ] *Workshops and groups will provide an opportunity for peer support & provide you with new self-management & coping strategies.* | **Befriending Support**  [ ] *Community supporters to local services and support to access & build social & community networks & activities in order to foster social inclusion & improve quality of life.* | **Peer Navigation Support** [ ] *Support with benefits, housing, employment, training, education and support you to access community services and help you get involved with your community.* | **Substance Misuse Support** [ ] *Workers from Change, Grow, Live (CGL). Support to listen to concerns, offer advice, harm reduction, referral, guidance & advocacy for people with drug & alcohol issues & help them get into treatment.* |
| **Complete Section: A** | **Complete Section: B** | **Complete Section: C** | **Complete Section: D** |
| **Section A: Workshops and Groups** |
| Managing Anxiety [ ]  Anger Management [ ]  Employment/ Training[ ]  Mindfulness [ ]  Confidence building [ ]  Managing Sleep [ ]  Other (please state): |
| **What would the patient like to achieve?** |
| **Section B: Befriending Support** |
| **Hobbies and interests:**Sports [ ]  Reading/Writing [ ]  Art/ Painting [ ]  Cooking/ Baking [ ]  Travelling [ ]  Puzzles/Games [ ]  Gardening [ ]  Community Activities [ ]  Computing/IT [ ]  Other (please state): |
| **What would the patient like to achieve?** |
| **Section C: Peer Navigation** |
| **Support required:**Accommodation [ ]  Employment/ Training[ ]  Education [ ]  Finances/Debt [ ]  Council Tax/Benefits [ ]  Volunteering [ ]  Health Advice [ ]  Other (please state):  |
| **What would the patient like to achieve?** |
| **Section D: Substance Misuse:** |
| **Substance Used:**Drug [ ]  Alcohol [ ] **Route of Administration:**Inject [ ]  Sniff [ ]  Smoke [ ]  Oral [ ]  Other (please state): **How often is this used:**Monthly or less [ ]  2-4 times per month [ ]  2-4 times per week [ ]  5-7 times per week [ ]  Everyday [ ]  Other (please state):**How many Drugs/ Alcohol do you have a day**0-2 [ ]  3-4 [ ]  5-6 [ ]  7-9 [ ]  10+ [ ]  Other (please state): |
| **Summary of Drug and Alcohol use:**  |
| **What would you the patient like to achieve?** |
| **Risk Management** |
| **Who does the patient live with:**Alone [ ]  With Spouse/partner [ ]  With Family [ ]  In Residential Accommodation [ ]  Prefer not to say[ ]  Other(Please state):**Does the patient have parental responsibility for children aged under 18?** Yes [ ]  No [ ]  Declined to answer [ ] **Do any of the children live with the patient?**Yes [ ]  No [ ]  Other(Please state): |
| **Are there any Safeguarding concerns related to the patient?**Yes [ ]  No [ ]  **If yes, please provide details** |
| **Does the patient display any behavior which can increase risk to themselves or others?** |

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| **Processing and Disclosing Data:** |
| I understand that Rethink Mental Illness may be required to provide my personal data to the public body which commissions Rethink Mental Illness services.I confirm staff have discussed with me the circumstances when and the reasons why they may have to disclose personal data without my consent.I am happy for Rethink Mental Illness may use my personal data, including concerning my health, to undertake evaluation and research in order to help plan and improve services.I give consent for Rethink Mental Illness to use my personal data as explained in this form, and to share the following data with the following agencies or individuals.  |
| **Has the person provided consent to be referred to Rethink Mental Illness?**Yes [ ]  No [ ]  |