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| **REFERRAL FORM** | | | | | | | |
| **Referral Completed by:**  **Self Referral -** | | | | **Job Title:** | | | |
| **Contact Details:** (*Please provide email, phone)* | | | | **Date of Completion:** | | | |
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| **PERSONAL DETAILS** | | | | | | | |
| **Title: Mr /Mrs /Miss/Ms/ other** | | | **Forename:** | **Surname:** | | | **Date of birth:** |
| **Address & Postcode:** | | | **Telephone:**  (Home/Mobile) | **Gender:**  Male  Female  Gender Fluid  Non Binary  Prefer not to say  Transgender | | | **Interpreter required:**  Yes  No  Preferred Language:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Area:**  Dover  Folkestone | **Ethnic Origin:**  White British  White-Irish  Other White  White: Gypsy or Irish Traveller  Black/Black British – Caribbean  Black/Black British – African  Black/Black British - other  Mixed: White and Black Caribbean  Mixed: White and Black African  Mixed: White and Asian  Mixed other  Asian/Asian British Pakistani  Asian/Asian British Bangladeshi  Asian or Asian British: Indian  Asian Other  Chinese  Prefer not to say  Other (please state):……………………………………… | | | | | | |
| **Religion:**  Agnostic  Atheist  Buddhist  Christian  Hindu  Jewish  Muslim  Sikh  No Religion or Belief  Declined to disclose  Other (please state): …………………………………………  **Sexual Orientation:**  Bisexual  Gay  Lesbian  Heterosexual  Queer  Pansexual  Asexual  Prefer not to say  Other (please state): ……………………………………… | | | | | | | **Relationship:**  Single  Married  Separated  Widowed  Divorced  Civil Partnership  Co-Habiting |
| **GP Practice** | | **Name:** | | | | **Telephone/Email:** | |
| **Address:** | | | | | |
| **Emergency Contact:** | | **Name:** | | | **Telephone:** | | |
|  | | **Address:** | | | | | |
| **Disability; Please identify if you have any of the following**  **Hearing impairment -**  **Visual impairment -**  **Physical Disability -** | | | | | | | |

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| **Mental Health needs** *(Please tell us about your mental health needs, Do you have a diagnosis?, Are you receiving mental health support already?, How are you feeling at the moment?* | |
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| **Do you know which parts of the service you want to use?** You can use both parts or one of the other. | |
| **121 Peer Support**  Peer support is where people with similar experiences come together to support each other in a safe space where everyone's experiences are equally important with no-one person being the expert At Rethink Mental Illness, a ‘peer’ is a someone with lived experience of mental illness who helps others to build relationships, achieve goals and connect with those who understand them.’  Our 121-peer support is goal focused, person centred, time limited 121 support to help you improve your mental health and wellbeing and access other services. | **Peer Support Groups**  Our Peer Support Groups are time limited service-led groups where you can access peer support from others with similar experiences and cover specific topics such as anxiety, hearing voices, assertiveness etc.  We will also be providing ongoing support for people to set up and attend peer-led long term peer support groups. These can take any form such as music or art or groups or for talking and coming together. |
| **What would you like to achieve when we work together?** | |
| **A bit more about you…** | |
| **Who do you live with?:**  Alone  With Spouse/partner  With Family  In Residential Accommodation  Prefer not to say Other(Please state):……………………………………………………  **Do you have a parental responsibility for children aged under 18?**  Yes  No  Prefer not to say  **Do any of the children live with you?**  Yes  No  Other(Please state):……………………………………………………  **Are you a carer?**  Yes  No  Prefer not to say | |
| **Do you have any concerns about your own safety or feel at risk from anyone? Do you have any concerns for anyone else’s safety? If yes please tell us about this below** | |
| **Do you have any other services providing you with support?** | |
| **How would you like us to make initial contact with you?**  **E.g Phone, Post, Text, Email.** | |

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| **Processing and Disclosing Data:** |
| I understand that Rethink Mental Illness needs to process my personal data, including data concerning my health and welfare, to process my referral for Rethink Mental Illness services and to provide these services to me. |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |