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**Access Community Mental Health Referral Form**

A community team working alongside people to find ways towards managing their mental health.

**This includes:**

* Person-centred planning and goal setting
* Solution-focussed conversations
* Identifying a group in the community to participate with
* Support to access other services
* Providing information about coping strategies
* Peer support - conversations with people with lived experience
* Up to eight weeks of support sessions

|  |  |
| --- | --- |
| **1. Referrer details** | |
| Date: |  |
| Name: |  |
| Job Role: |  |
| Organisation/Service: |  |
| Phone number: |  |
| Email address: |  |

|  |  |
| --- | --- |
| **2.Details of person being referred** | |
| Forenames: |  |
| Surname: |  |
| Date of birth: |  |
| Gender: | Female  Male  Non-binary  Gender fluid Other  Prefer not to say  Not provided |
| Preferred Pronouns: | He/him  She/her  They/them  Other  Prefer not to say  Not provided |
| Email address: |  |
| Contact phone number(s): |  |
| Preferred method of contact: | Text Phone  Email  Not provided |
| Address: |  |
| Sexual orientation: | Asexual  Bisexual  Gay  Heterosexual/straight  Lesbian  Not provided  Other  Pansexual  Prefer not to say  Queer  Questioning |
| Ethnicity: | Asian or Asian British:  Bangladesh  Chinese  Indian  Pakistani  Other    Black or Black British:  African  Caribbean  Other  Mixed:  White Asian  White and Black African  White and Black Caribbean  Other  White:  British  Irish  Other  White gypsy or Irish traveller  White: Roma  Other:  Arab  Other Ethnic Group  Prefer not to say  Not provided |
| **Name of GP surgery and contact number:** |  |

|  |
| --- |
| **3. Reason for referral.** |
|  |

|  |  |
| --- | --- |
| **4. Additional information – Please share anything that maybe helpful.** | |
|  | |
| **5. Diagnosis** | |
| Primary Diagnosis: |  |
| Source of Diagnosis: |  |

|  |  |
| --- | --- |
| **6. Goals** | |
| What goal or goals, would the person referred like to achieve? |  |

|  |  |
| --- | --- |
| **7. Consent** | |
| Consent to referral: | Yes  No |

|  |  |
| --- | --- |
| **8. Risk** | |
| **Risk type** |  |
| Harm to self: | Yes  No  If yes, please give details: |
| Harm to others: | Yes  No  If yes, please give details: |
| Harm from others: | Yes  No  If yes, please give details: |

**Wellbeing line: 0808 280 3528 – 7 days a week 9am-11pm**

**Thank you, please return the form to** [**AccessWiltshire@rethink.org**](mailto:AccessWiltshire@rethink.org)

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