  

**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

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

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| **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 [ ]  OtherMixed: [ ]  White Asian [ ]  White and Black African [ ]  White and Black Caribbean [ ]  OtherWhite: [ ]  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:**   |  |

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| **3. Reason for referral.** |
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| **4. Additional information – Please share anything that maybe helpful.** |
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| **5. Diagnosis** |
| Primary Diagnosis: |  |
| Source of Diagnosis:  |  |

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

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| **7. Consent** |
| Consent to referral:  | [ ]  Yes [ ]  No |

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|  **8. Risk**  |
| **Risk type** |  |
| Harm to self:  |  [ ]  Yes [ ]  NoIf yes, please give details:  |
| Harm to others:  |  [ ]  Yes [ ]  NoIf yes, please give details: |
| Harm from others: |  [ ]  Yes [ ]  NoIf 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**

  