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|  |  | | **Referral Date:** | |  | |
| ***SERVICE USER DETAILS***  **\*** = essential information for referral to be processed. | | | | | | |
| **Full Name \*** | Mr/Mrs/Miss/Ms | | | **Marital Status** | |  |
| **Current Address \*** | **Postcode:** | | | | | |
| **Date of Birth \*** |  | | **Gender \*** | |  | |
| **Contact Details \*** | Home: Mobile:  Email: | | | | | |
| **Ethnic Origin** |  | | **Religion** | |  | |
| **Preferred Spoken Languages** |  | | **Interpreter required?** | | Yes / No | |
| **Primary Mental Health Diagnosis / Concern \***  *(eg anxiety/depression, please provide full details in Current Circumstances section on page 2)* | |  | | | | |

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| --- | --- | --- | --- | --- |
| ***REFERRER DETAILS (if applicable – leave blank if a Self-Referral)*** | | | | |
| **Organisation / Agent** |  | **Relationship to individual** |  | |
| **Name** |  | | | |
| **Address** |  | | | |
| **Email Address** |  | | | |
| **Telephone Number** |  | | | |
| **Referrers Signature** | Date: | | | |
| **Does the individual AGREE to the referral? (please delete) \*** | | | | YES / NO |

|  |  |
| --- | --- |
| **Preferred contact method (please tick) \*** | **Telephone □ Text □ Email □ Letter □** |
| **How did you hear about the service?**  **(eg leaflet, professional, website, etc.)** |  |

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| *SERVICE USER INFORMATION (Please state)* | | | |
| **Current Circumstances**  (Please include details of current diagnosis or mental health symptoms at this time, any physical health needs, and any external factors that are currently impacting on the individual.)  **Does the client have any communication / information needs relating to a disability or sensory loss?** | | **Y / N** (If yes please give details) | |
| **Is there anything we need to be aware of when lone working? \***  (e.g. are there any concerns to self and/or others, any criminal convictions or incidents of violence we should be aware of)  (If available, please attach risk assessment no older than 6 months) | |  | |
| **Any other relevant information**  (e.g. financial, addiction, housing, immigration, etc.) | |  | |
| **What inclusion support would the service user benefit from? \***  (eg in which areas do you feel support is needed – group activities; community engagement, access online etc.) | |  | |
| *Please tick if interested*  *in accessing the following:* | **□** Greener Health Project  *(BA14 & BA15 area only)* | | **□** Digital Tech Buddy Scheme |

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| *Completed form to be returned to:* | |
| Wiltshire Mental Health Inclusion Service  email: [WiltsMHIS@rethink.org](mailto:WiltsMHIS@rethink.org) | Service Manager telephone:  07467 764171 |

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| *(For Office Use Only)* | |
| **Name of person taking referral:** |  |
| **Date** |  |