|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| New |  |  | Re-Referral |  |  | Close |  |

|  |  |
| --- | --- |
| Client ID |  |

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**Referral Form**

**Staff only section**

|  |  |  |  |
| --- | --- | --- | --- |
| **Wellbeing Coordinator:** |  | | |
| **Referral date:** |  | **Date initial assessment is offered:** |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section One: Your Details** | | | | | | | | |
| **Name:** |  | | | | | | | |
| **Contact address:** |  | | | | **Postcode:** | |  | |
| **Contact number(s)** |  | | | | | | | |
| **Email:** |  | | | | | | | |
| **Date of birth:** |  | | **NHS number:** | | |  | | |
| **GP Practice:** |  | | | | | | | |
| **Preferred contact:** | Letter  Phone  Email  Text | | | | | | | |
| **Preferred language if not English:** |  | | | | | | | |
| **Referral Source:** | GP Practice  Self  Other Professional  Third Party  CMHT  Carer | | | | | | | |
| **Section Two: Reason for referral** | | | | | | | | |
| **Primary reason** (select one that applies) | |  | | **Secondary reasons** (select as many that apply) | | | |  |
| Feeling lonely or isolated | |  | | Feeling lonely or isolated | | | |  |
| Feeling stressed or anxious | |  | | Feeling stressed or anxious | | | |  |
| Need advice on health, housing or finance issues | |  | | Need advice on health, housing or finance issues | | | |  |
| Need emotional support | |  | | Need emotional support | | | |  |
| Want to find out about local groups and activities | |  | | Want to find out about local groups and activities | | | |  |

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| **Referral Notes:** |
|  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Details of any other agencies or professionals involved in your support and care within the past 6 months** | | | | | | | |
| **Organisation** | | | **Worker** | | | **Contact Number** | |
|  | | |  | | |  | |
|  | | |  | | |  | |
| **Do you have any specific physical support requirements that would prevent you from seeing us at your GP practice?** | | | | | | YES  NO | |
| **Please give details if yes:** | | | | | | | |
| **Section Three: Risk** | | |  | | | | |
| Who is assessing the risk? Please state: | | | | | | | |
| **Person above’s perception of risk (please rate the following)** | | | | | | | |
| **Risk** | | | | | | | |
| Self-injury |  | **Low** | | **Medium** | **High** | | **Not known** |
| To public |  |  | |  |  | |  |
| To staff in workplace |  |  | |  |  | |  |
| To staff during home visit |  |  | |  |  | |  |
| To property |  |  | |  |  | |  |
| Isolation |  |  | |  |  | |  |
| Self-neglect |  |  | |  |  | |  |
| Relapse |  |  | |  |  | |  |
| Offending |  |  | |  |  | |  |
| Domestic abuse |  |  | |  |  | |  |
| Other – please state: |  |  | |  |  | |  |
| **Please give further detail for any areas scoring medium or high (including criminal convictions)** | | | | | | | |
|  | | | | | | | |

**Please select one of the statements below that applies.**

**I confirm that verbal consent has been given to me to make a referral on this person’s behalf. They’re aware that the information given on this form and in any future contact with Connect Well will be used to provide them with support and will be kept confidential. The information given may also be used for monitoring purposes within the Connect Well service and its partners.**

**Name**

**Position**

**Signature**

**OR**

**I give consent to Connect Well and its employees to contact me. I understand that the information I give on this form and in any future contact with Connect Well will be kept confidential. I understand that the information given may also be used for monitoring purposes within the Connect Well service and its partners.**

**Name**

**Signature**

Please return this form to [commlinks.connectwell@nhs.net](mailto:commlinks.connectwell@nhs.net) or

Connect Well

The Reginald Centre

Leeds

LS7 3EX

|  |
| --- |
| **Equal Opportunities** |
| Connect Well strongly believes that particular groups of people are at risk of finding services inaccessible, or of experiencing on-going poor mental health and poor quality of life. We need to make sure that we are an accessible service and to do this we must monitor the referrals that we receive to make sure that we are reaching all sections of society. The information is used for monitoring and statistical reasons only. |

|  |  |  |
| --- | --- | --- |
| **What is your age group?**  18-24  25-34  35-44  45-54  55-64  65+ | **Do you have any of the following?**  Anxiety & depression  Anxiety disorders  Bipolar  Depression  Obsessive compulsive disorder  **\*\*\***  Alcohol problem  Drug problems  Dual diagnosis MH/Drugs  Dual diagnosis MH/Alcohol  **\*\*\***  Alzheimer’s  Dementia  Memory Impairment / confusion  **\*\*\***  Learning disability  Learning disability / MH  **\*\*\***  None  **Are you a carer?**  Yes  No | **What is your cultural background?**  **Asian or British Asian**  Bangladeshi  Indian  Kashmiri  Pakistani  Other  **Black or Black British**  African  Caribbean  Other  **Mixed**  White & Asian  White & Black African  White & Black Caribbean  Other  **Other Ethnic Groups**  Chinese  Gypsy/Traveller  Other  **White**  British  Other  Irish  Prefer not to say |
| **How do you identify yourself (gender)**  Female  Other  Male |
| **Is this the gender you were assigned at birth?**  Yes  No  Prefer not to say |
| **How do you identify yourself (sexuality)**  Bisexual  Lesbian  Gay  Prefer not to say  Heterosexual / straight  Self-defined |
| **Do you have a religion?**  Buddhist  Muslim  Christian  Sikh  Hindu  None  Jewish  Other  Prefer not to say |

See overleaf for more options

|  |  |  |
| --- | --- | --- |
| **Your relationship status**  Civil partnership  Married  Co – habiting  Separated  Divorced  Single  In a relationship  Widow  Prefer not to say | **Do you have a health problem that affects your life on a day to day basis, or consider yourself to be physically disabled?**  Yes  No  Prefer not to say | **Your residency status**  Asylum seeker  Foreign Student  British citizen  Leave to remain  Destitute  Other  EU National  Refugee  Prefer not to say |
| **Welfare support and benefits**  Employment & support allowance  Other  Housing benefit  PIP  Income support  State pension  Job seekers allowance  Tax credits  None  Universal credit | **If yes, please select type of condition(s)**  Hearing impairment  Long standing illness / health condition  Mental health condition  Visual impairment | **Your employment status**  Employed  Retired  Employed part time  Self-employed  Not employed Other |