**Referral Form – Section One** (Please print or use block capitals)

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| **Referral to:**(Please tick service you wish to refer in to) | Group Support and Activities - Hull  [ ]  | Vocational Support and Employability- Hull and ER  [ ]  | Bereavement Support – East Riding  [ ]  |   |
| One to One Support – East Riding  [ ]  | Group Support and Activities– East Riding  [ ]  | Offender or Prison Mentoring- Hull and ER [ ]  | Young Persons Group – Hull and ER [ ]  |
| Other available services.  | Please note if you would like to refer in to our Housing service or Floating Support you will need to call 01482 448856.For counselling services the client will need to call Let’s Talk (Hull) on 01482 247111 or the Emotional Wellbeing Service (East Riding) on 01482 301701.For our Stress Management course please call 01482 240200 or request specific referral form. |

If you are unsure about which service to refer in to, or would like more information please call our Information line on 01482 240133 or email info@heymind.org.uk

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| Referring agency/If you are referring yourself how did you hear about us:  |
| Contact name: | Contact number: | Email address: |
| Date Referred: |

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| **Client** **Information** | Title: | First Name:  | Surname: |
| Telephone number:  | Postal Address:  |
| Alternative telephone number: |
| Email address: | Postcode: |
| Registered GP:  | Date of Birth:  |
| Next of kin name/relationship  | Next of kin telephone number: |

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| Please give details of your/the clients mental health issues (eg anxiety, depression): |

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| Please give details of any of your/the clients physical health issues (eg mobility problems): |
| Do you/ does the client have any alcohol or drug related problems? *(please specify)* |
| Are you/ is the client accessing or currently being supported by any other agencies eg GP, CMHT, Employment Support Agency? |
| As an equal opportunities organisation we would like to ensure that we meet your needs; do you have any specific requirements which would assist us to do this? |
| How would you like us to help the client/you: |
|  |
| Addition information: |

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| --- | --- |
| GP Address: |  |
| Details of any current medication: No |

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| Do you harm yourself or have you done so in the past? | Yes [ ]  | No [ ]  |
| Have you harmed or caused injury to others? | Yes [ ]  | No [ ]  |
| Do you have thoughts of harming yourself or others? | Yes [ ]  | No [ ]  |
| Do you have any anger management issues? | Yes [ ]  | No [ ]  |
| If you have answered yes to any of the above please give details: |

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| How would you like us to keep in touch with you/the client? |
| Phone [ ]  | Email [ ]  | Post [ ]  | Other (please state) [ ]  |

**Please return your completed referral form to the address above.**

For office use only

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| Date Acknowledged: | Initial Contact: |