**Mental Health Wellbeing and Recovery Services**

Referral Form

**Provider Details for Referral Forms:-**

**Leicester City, Oadby, Wigston & Blaby**

**Richmond.fellowshiplifelinks@nhs.net****. Free Phone 0800 0234575 (SPOA)**

**1st Floor 60 Charles Street, Leicester. LF1 1FB**

**Charnwood, North West Leicestershire, Hinckley & Melton**

**leicestershire.andrutland.mhm@nhs.net** **Free phone 0300 3230 189 Single Point of Access: Swithland Suite The Crescent, 27 King Street, Leicester LE1 6RX**

**Harborough**

Harborough.mindmatters@nhs.net **01858 411383**

**1st Floor Torch House, Torch Way, Market Harborough, Leicestershire LE16 9HL**

|  |  |
| --- | --- |
| **Full Name** |  |
| **Date of Birth** |  |
| **Current address**  |  |
| **Contact Number** |  |
| **Email Address** |  |
| **NHS Number** |  |
| **GP Name address & Contact number** |  |
| **Ethnicity** |  |
| **Gender Preference** |  |

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| **If you are referring someone into the service please print your details and confirm that you have gained consent from the individual being referred.****Name…………………………………………………….. Date……………………………….****Email……………………………………………………… Tel………………………………...****Job Title…………………………………………………. Consent Gained Yes/No** |

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| **Reasons for referral** |
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| **Any Specific Support e.g. interpreter** |
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| **Known Risks (detail any evidence of risk in the areas listed - Yes or No or not known)**  |
| **Dangerousness / risk to others** |  | **Details:**  |
| **Risk of self-harm / Self-neglect** |  |
| **Known to Social Services**  |  |
| **Suicidal Thoughts / Attempts** |  |
| **Substance Misuse** |  |
| **Physical / Verbal Aggression** |  |  |
| **Other** |  |  |
| **Signature of referrer: Date:** |

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| **By signing this form I give consent to the organisation receiving personal information from my referral agent and or any other agencies involved in my current or previous care/support. I understand that they will handle all information in line with Data Protection Legislation and their own Confidentiality and Information Governance Protocols.****Signature……………………………………………. Date………………………………..** |

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| **Names of any other professionals or organisations involved** |
| **Name** | **Contact Details**  |
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**Internal Use only:**

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| **Date received**  |  |
| **Date Actioned** |  |
| **Outcome : Telephone support, 1-1 support ,Signposting** |  |
| **Assigned to**  |  |
| **Signed** |  |
| **Date** |  |



**Mental Health Wellbeing and Recovery Services Funded by:**

