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| **GENERAL**  | **Tamworth, Lichfield & East Staffordshire Your Way****REFERRAL FORM** |
| **FOR SOCIAL AND COMMUNITY SUPPORT AS A RESULT OF MENTAL HEALTH ISSUES** |
| Referral Date |       | Service/Team |       |
| Referrers Name |       | Job Title |       |
| Phone |       | Email |       |
| Address |       | Post Code |       |
|  |
| **PERSON BEING REFERRED’S BASIC INFORMATION** |
| Name |       | D.O.B |       |
| Preferred Name |       | Post Code |       |
| Address |       | Phone |       |
| Email |       | Reason for Referral |       |
| How Did You Hear About Us? |       | Preferred method of contact |       |
|  |  |  |  |
| **REASON FOR REFERRAL** |
| * Please indicate below which areas are applicable for the person you are referring below and provide more information about why this is important.
* Referrals may not be accepted if sufficient supporting information is not provided.
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| Developing Coping Strategies & Improving Mental Wellbeing  |[ ]  Access Volunteering  |[ ]
| Education and Training  |[ ]  Support towards employment |[ ]
| Reducing Isolation & taking part in the community  |[ ]  Healthy Lifestyle: e.g. nutrition, physical activity  |[ ]
| DWP Benefits, Finances, Debt or Housing  |[ ]  Maintain relationships and/or caring responsibilities  |[ ]
| If checked boxes above, provide more information on the reason for referral here.  |  |
| **Other Support:**Provide details of any relevant supporting professionals, carers or services involved  |  |
| **Risk information** Provide overview of any relevant risk information |  |
|  |  |
| **CPA STATUS, CONSENT AND RISK ASSESSMENT** |
| **CONSENT** | It is essential that consent is given for this referral and to being contacted, please check box to confirm:  | [ ]  |
| **RISK ASSESSMENT** | If you work in a statutory health service then you will need to send a risk assessment in with this referral. If a risk assessment is not sent then the referral will not be able to be accepted. Please check box to confirm that a risk assessment is attached.  | [ ]  |
| CURRENTLY ON A CARE PLAN THROUGH SECONDARY MENTAL HEALTH SERVICES | [ ]  |
| CARE PLAN NO LONGER NEEDED (but has been in the past 12 months) | [ ]  |
| IN THE PROCESS OF BEING ASSESSED BY SECONDARY SERVICES | [ ]  |
| REFERRED BY ACCESS TEAM & NOT ELGIBLE FOR SECONDARY SERVICES | [ ]  |
| **SEND THIS FORM TO:**  | **EMAIL:** Staffordshire-yourway@together-uk.org |
| Further information:  | PHONE: 01283 500 650WEBSITE: Staffordshire-yourway@together-uk.org |