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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. | | | | | | | | |
| 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](mailto:Staffordshire-yourway@together-uk.org) | | | | | |
| Further information: | | | PHONE: 01283 500 650  WEBSITE: [Staffordshire-yourway@together-uk.org](mailto:Staffordshire-yourway@together-uk.org) | | | | | |