**Adult Referral Form**

Date Admin Charity Log#

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| **FULL NAME** |  |
| **PREFERRED NAME** |  |
| **ADDRESS** |  |
| **POSTCODE** |  |
| **DATE OF BIRTH** |  |
| **GENDER** |  |
| **ETHNICITY** |  |
| **MAIN LANGUAGE** |  |
| **GP NAME & SURGERY** |  |
| **ARE YOU TAKING ANY PRESCRIBED MEDICATIONS? PLEASE STATE:** |  |
| **LANDLINE PHONE NUMBER** |  |
| Can we leave a message?  | **YES** **NO**  |
| **MOBILE PHONE NUMBER** |  |
| Can we leave a message? | **YES****NO**  |
| **EMAIL ADDRESS** |  |
| **CONTACT PREFERENCE** |  |
| **HOW DID YOU HEAR ABOUT US?** |  |
| **EMERGENCY CONTACT**NameRelationship to ClientContact Telephone number |  |
| **EMPLOYMENT STATUS**(Please Circle) | Employed (Full Time) Employed (Part time)Self Employed UnemployedRetired In Education |
| **DO YOU HAVE CARER RESPONSIBILITIES** |  |
| **DO YOU HAVE ANY DISABILITIES** |  |
| **REFERRER NAME & TITLE** |  |
| **REFERRER ORGANISATION** |  |
| **REFERRER PHONE NUMBER** |  |
| **REFERRER EMAIL** |  |

 **PRESENTING ISSUES**

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| **ABUSE** |  | **OCD** |  |
| **ADHD** |  | **POST ABUSE** |  |
| **ANGER** |  | **PREGNANCY RELATED ISSUES** |  |
| **ANXIETY/WORRIES** (Life in General) |  | **PTSD** |  |
| **DEPRESSION** |  | **RELATIONSHIPS** |  |
| **DIAGNOSED EATING DISORDER** |  | **RISK TAKING BEHAVIOUR** |  |
| **DIAGNOSED PERSONALITY DISORDER** |  | **SELF ESTEEM** |  |
| **DOMESTIC VIOLENCE** |  | **SELF HARM** |  |
| **FAMILY RELATIONSHIP PROBLEMS** |  | **SEXUAL OFFENDING**  |  |
| **GRIEF AND LOSS** |  | **SUBSTANCE MISUSE** (Drugs & Alcohol) |  |
| **ILLNESS** (Self) |  | **SUICIDAL THOUGHTS** |  |
| **ILLNESS** (Others) |  | **TRAUMA** |  |
| **ISSUES AROUND SEXUALITY / GENDER** |  | **WORK RELATED ISSUES** |  |
| **LOW MOOD** |  |  |  |

 **ADDITIONAL INFORMATION**

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| Please use this section to help us understand why you are looking for some support. |

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| Please state any Services you have/are receiving support from. Any Social Service Involvement: If yes, what level (Family support, Child protection etc.) |

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| **By signing this form, I agree to Mid Cheshire Mind retaining my data, which will not be passed on to any other party without my explicit consent.** |

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| --- | --- | --- | --- |
| **Signature** |  | **Date** |  |
| **Referrer signature**(if applicable) |  | **Date** |  |

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| I give my consent for Mid Cheshire Mind to contact my GP and any other relevant third party only in case of emergency and for safeguarding purposes. |

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| **Consent Given**  |  **YES** |  **NO** |

**\*\*\*\* TO BE COMPLETED BY MID CHESHIRE MIND STAFF- FOR OFFICE USE ONLY \*\*\*\***

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|  **RISK ASSESSMENT** |
| **Conducted by: Date:****Initial phone assessment? YES**  **NO (Not req’d- to be completed session 1 with practitioner)** |
| **Any deliberate Self-Harm, Suicidal Thoughts, Risk taking behavior?****Intent to Act:****0 1 2 3 4 5 6 7 8 9 10****No Risk High Risk**  |