

 **Adult Referral Form**

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| **Date Received** |  |
| **Charity Log number**  |  |
| **Administrator Name** |  |

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| **Personal Details** |
| **Full Name** |  |
| **Preferred Name** |  |
| **Address****Postcode** |  |
| **GP Name & Practice** |  |
| **Are you taking any prescribed medication? Please state:** |  |
| **Gender** |  |
| **Date of Birth**  |  |
| **Ethnicity** |  |
| **Main Language** |  |
| **Landline Telephone Number****Can we leave a message?** |  |
| **Mobile Telephone Number****Can we leave a voicemail?****Can we send a text?** |  |
| **Email Address** |  |
| **Preferred method of contact** |  |
| **How did you hear about us?****Please state:** |  |
| **Emergency Contact Details****Name****Relationship to Client****Contact Telephone Number****Email Address** |  |
| **Client Status** |
| **Employed (Part time)** |  |
| **Employed (Full time)** |  |
| **Self employed** |  |
| **Unemployed** |  |
| **In Education** |  |
| **Retired** |  |
| **Do you have any Carer responsibilities?****Do you look after, or give any help or support to a family member, friend or neighbour because of long term physical disability, mental ill-health or problems related to old age?** |  |
| **Referrer Details** |
| **Referrer Name (if applicable)** |  |
| **Job Title****Service/Organisation** |  |
| **Contact Telephone Number** |  |
| **Email Address** |  |
| **Presenting Issues** |
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| **Abuse**  |  | **Relationships** |  |
| **Anger** |  | **Substance Misuse (Drugs & Alcohol)** |  |
| **Anxiety/Worries (Life in General)** |  | **Sexual Offending** |  |
| **Carer Responsibilities** |  | **Suicidal Thoughts** |  |
| **Diagnosed Eating Disorder** |  | **Self-Harm** |  |
| **Diagnosed Personality Disorder** |  | **Trauma** |  |
| **Domestic Violence** |  | **Work-Related Issues** |  |
| **Depression** |  | **ADHD** |  |
| **Self Esteem** |  | **Illness (self )** |  |
| **Grief & Loss** |  | **Illness (others)** |  |
| **Low Mood** |  | **OCD** |  |
| **Issues around Sexuality/Gender** |  | **PTSD** |  |

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| **Additional Information** |
| *Please include any* ***diagnosed mental health conditions****/significant losses/life events.* |
| **Services that you have/are receiving support from** **(Please state whether past or ongoing support)** |
| ***Any Social Service Involvement; if yes what level (Family Support, Child in Need, Child Protection)*** |
| **I give my consent for Mid Cheshire Mind to contact my GP and any other relevant professional third parties.** **Consent Given: YES NO**  **WRITTEN/VERBAL****By signing this form I agree to Mid Cheshire Mind retaining my data, which will not be passed onto any other party without my explicit consent.**  |
| **Signature** |  | **Date** |  |
| **Referrer Signature (if applicable)** |  | **Date** |  |

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

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| **Risk Assessment** |
| **Conducted by:****Initial Telephone Assessment? YES (Date: )**  **NO (Not required- To be completed in Session 1 with Practitioner)**Any Deliberate Self-Harm, Suicidal Thoughts, Risk-taking Behaviour? **Intent to Act:** **0 1 2 3 4 5 6 7 8 9 10** **No Risk High Risk** **GAD7/PHQ9 Questionnaires completed? YES (Gad7 Score = PHQ9 Score = )** |

**Ongoing Session Details**

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| **Service Type:****(Counselling, EWS support with MHSWs, Group – state which group)** | **Type of contact:****Telephone/F2F/HV** | **Availability for Appointments** **Days & Times** |
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| **Referral Type, please indicate:** | Self-referralProfessional (on Client’s behalf)Non-Professional (on Client’s behalf) |
| **Referral Method:** |  |

Allocated to (Name of Practitioner):

Start Date/Time: