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**Healthy Minds Community Programme**

**Referral Form**

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| **Section One – Internal Use Only** | | | | | | | | | | | | | | | |
| Date:  Referral taken by:  (Person completing initial meeting)  Method: | | | | | How did you hear about HMCP:  Navigator Opt in? Yes | No  Interested in GSTG: Yes | No | | | | | | | | | | |
| **Section Two - Personal Details** | | | | | | | | | | | | | | | |
| First name: | | | | | Surname: | | | | | | | | | | |
| Preferred name: | | | | | D.O.B: | | | | | | | | | | |
| Gender: Male/ Female/ Transgender/ Other | | | | | Email: | | | | | | | | | | |
| Mobile: | | | | | Home: | | | | | | | | | | |
| Address: |  | | | | | | | | | | | | | | |
| Preferred method of contact: | Mobile | | | Home Phone | | | | | | Email | | | | Letter | |
| Would you like to receive our email newsletters?  Yes | No | | | | | | Would you like to receive our text message updates?  Yes | No | | | | | | | | | |
| Emergency Contact | Name:  Contact Number:  Relationship:  Additional information: | | | | | | | | | | | | | | |
| Date of first meeting: |  | | | | | | | | | | | | | | |
| **Ethnicity – Please Circle** | | | | | | | | | | | | | | | |
| White | English/Welsh/Scottish Northern Irish/British | | | Irish | | | | | | Gypsy/Irish Traveller | | | | Other White background | |
| Mixed | White & Black Caribbean | | White & Black African | | | | | | | White & Asian | | | Other Mixed | | |
| Asian/Asian British | Indian | Pakistani | | | | | | Bangladeshi | | | Chinese | | | | Other Asian |
| Black/African/Caribbean/British | African | | | | | | Caribbean | | | | | Other Black/African/Caribbean background | | | |
| Other Ethnic Group | Arab | | | | | | | | Other Ethnic Group | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Section Three – Self Assessment** | | | | | | | |
| Do you identify yourself as having physical or learning needs? | | | Yes | | | No | |
| If you answered yes, please could you provide us with more detail to ensure we can best support you | | | | | | | |
| Do you identify yourself as having mental health needs? | | | Yes | | | No | |
| If you answered yes, please could you provide us with more detail to ensure we can best support you | | | | | | | |
| Referrer Details:  Or  Care coordinator:  (please indicate which) | Name:  Address:  Email Address:  Contact Number: | | | | | | |
| Cluster:  (if applicable-circle as appropriate) | Psychosis Services (Recovery & Rehabilitation) | Services for Ageing and Mental Health (SAMH) | | Psychosis Services (Outreach) | Non-Psychosis Services (Community Mental Health) | | Other: |

When I have difficult days with my mental or physical health, is there anything I struggle with in particular?

*e.g: My sleep, my mood, my self-care, suicidal thoughts, anger*

Are there any triggers which make things worse for me and how best can these be managed?

What risks can I present to myself or others (if any)?

What helps me?

*I agree that Mind in Camden may need to share information from this form, and any concerns regarding my health or welfare with partner organisations who I engage with through Healthy Minds, and/or named professional.*

*Signed……………………………………………………………………………………………*