HAVERING MIND
Harrow Lodge House, Hornchurch Road, Hornchurch Essex RM11 1JU
Telephone: 01708 457040 Fax: 01708 457141
Email: reach.us@haveringmind.org.uk

Referral Form

Note: Harrow Lodge House is wheelchair accessible to ground floor only

☐ **Community Navigator Service 1:1 Volunteer Support**

☐ **Gateway Mental Health Advice and Guidance Session**

☐ **Older Adult Supported Peer Group**

☐ **18 - 30's Programme**

☐ **Live a Better Life (Health & Wellbeing)**

We accept Self-Referrals (Additional information may be required)

Applicant's Personal Details:

Forename:.....Surname:.....Mr/Mrs/Ms/Miss

Address:.....

.....Post Code:.....

Home Phone No:.....Mobile:.....

Email:.....

Marital Status:..... Position in Family:.....Number of Dependants:.....

Date of Birth:.....Age:.....Place of Birth:.....

Gender: Male ☐ Female ☐ Other ☐ Please Specify.....

Accommodation Status:.....Caring for someone **YES/NO**

Employment Status at time of Record Creation: In Training / Education ☐ Paid Employment ☐ Volunteering ☐ None of the Above ☐

Nationality:.....Primary Language:.....

Interpreter Required:.....Communication Restrictions:.....

Refugee Status: Yes ☐ No ☐ Disability: Yes ☐ No ☐

Disability: (*Please specify)* .....

CPA Yes ☐ (If yes, please attach risk assessment) No ☐

Are you receiving support from Mental Health Services? *(Please Specify)*

.....

Diagnosis/Presenting Symptoms.....

.....

Are you taking prescribed Mental Health medication? Yes ☐ No ☐

Please give details of **ALL** medication here:

Physical/Learning Disabilities.....

Next of Kin Name..... Relationship.....

Address.....

.....

Post Code.....Tel No..... Mobile .....

Email.....

Permission to contact this person in case of crisis/emergency Yes ☐ No ☐

If **'No'** who else would you like contacted: .....

Any other action required in case of crisis/emergency? .....
……
……

Applicant's Ethnic Origin *Required*

White	Please Tick	**Mixed**	Please Tick
British		White / Black Caribbean	
Irish		White / Black Africa	
Any other White background		White Asian	
Black / Black British		Any other mixed background	
Caribbean		**Other Ethnic Groups**	
African		Chinese	
Any other Black background			
Asian or Asian British		**Any other ethnic group**	
Indian			
Pakistani		Not stated	
Any other mixed background			

Sexual orientation (Please tick box)

Heterosexual		Gay	
Other please state		Would rather not say	

Religion or Belief (Please tick box)

No religion		Jewish	
Christian		Muslim	
Buddhist		Sikh	
Hindu		Other Religion	

Please state issues you would like help with:

How long have you had this problem (e.g. weeks, months, years)?

Are you receiving help from any Mental Health Service? Yes ☐ No ☐

If **YES,** please state which service is supporting you

Do you have any on-going physical health problems? Please specify

Have you received, or are you currently receiving, treatment for this problem? Yes ☐ No ☐

If **YES,** please give details (e.g. what, when and for how long)

Are you currently taking any medication Yes ☐ No ☐

If **YES,** please give details

Are there any issues with alcohol or recreational drugs?	
Alcohol: **Please tick box**	Yes ☐ No ☐
Drugs: **Please tick box**	Yes ☐ No ☐
If **YES,** please specify:	

What outcomes would you like to see through using our services?
Please give specific examples.....
.....
.....
.....
.....

Risk Assessments: *Please attach if available*

1. Essential for Community Navigator Service
2. Essential for clients on enhanced CPA

Do you currently feel you are a risk to yourself: Yes/No
Do you currently feel you are a risk to others Yes/No
Do you currently feel at risk from others Yes/No
Forensic History: Yes/No
If Yes to any of the above, please specify:

Are your family or friends concerned about any of your behaviours Yes ☐ **No** ☐
If Yes, please give details:

Additional Information which may be helpful

(For example: *mental health history, living situation, dependants, access to home details , cultural needs, social situation, employment/education history, hobbies/interests, household pets etc.*)
Additional Information:
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Type of Referral **Self** ☐ **Agency** ☐

Name .....Tel No.....
Position..... Email .....
Referring Agency.....Team.....
Address.....
.....Post Code.....
Date of Referral……
Other Agencies involved.....

GP's Name *(required)*.....Tel No.....
Address.....
.....Post Code.....

Is there a known carer? Yes ☐ **No** ☐

Name.....
Contact Detail.....

Permission to contact carer Please Tick **No** ☐ **Yes** ☐

How/where did you hear about Havering Mind ?.....
.....

Thank you for taking the time to complete the referral form you now need to post or email to: reach.us@haveringmind.org.uk

Please note that unless you are sending the email from an encrypted system, this method of communication may not be secure. If you have any concerns about emailing it back to us, please post to the address below.

Havering Mind
Harrow Lodge House
Hornchurch Road
Hornchurch Essex RM11 1JU

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What happens next? – A member of our team will contact you in order to arrange an appointment to take place as soon as possible

Please note: Our service is not able to provide immediate support in an emergency. If you require immediate urgent help, please contact the NELFT 24 hour helpline: 0300 555 1000

CONSENT (MUST BE COMPLETED TO PREVENT A DELAY IN YOUR APPLICATION)

Consent to Receive Further Communications **YES** ☐ **NO** ☐

Communication Preferences Mail ☐ Email ☐ Telephone ☐ Text ☐

Informed Consent to Participate **YES** ☐ **NO** ☐

I agree to information sharing with other agencies in relation to the processing of this referral where required

Please view our privacy statement on our website: www.haveringmind.org.uk for further information

All communications with Havering Mind are protected by the Freedom of Information Act 2000

Applicant's Signature: **Date:**

Referrer's Signature: **Date:**

Referrer PRINT FULL NAME: