|  |  |  |  |
| --- | --- | --- | --- |
| Title: |  | Home address and postcode:  |  |
| Forename: |  |
| Surname: |  |
| Date of birth: |  |
| Home telephone no: |  | Address and postcode at time of referral (if different): |  |
| Mobile no: |  |
| Can messages be left? | Home: | Y/N | Mob: | Y/N |
| Email: |  |

|  |
| --- |
| **Accessibility information** |
| Preferred language: |  |
| Access needs: |  |
| Other requirements: |  |

|  |
| --- |
| **Demographic information**This information is used for monitoring purposes and to signpost service users to relevant services. Any information given should be determined by the person being referred, given voluntarily, and will be stored confidentially in line with data protection laws. |
| Gender: |  | Faith or Religion: |  |
| Ethnicity: |  | Sexual Orientation: |  |

|  |
| --- |
| **Safeguarding** |
| Any known risks? |  |
|  |
| Has the person being referred consented to this information being shared? | Y/N |

|  |  |
| --- | --- |
| **NHS No.**  | **Availability\*:** *Please circle appropriate times***M T W Th F****am am am am am****pm pm pm pm pm** |
| **Reason for referral (Please be as detailed as possible) \*:** **How long an issue\*:** **Any known risk issues\*?****Medication\*?** **Any other Services Involved with\*:** (Please be aware this includes social workers, parole officers, psychiatrists etc)  |
| GP Name and Surgery Address\*:  |
| Referred by\*: Date\*: Contact details\*: Role: |
| **Select all applicable below (adults)\* and provide details:*** A long history of mental health problems
* Severe mental health issues: psychosis, hearing voices, hallucinations
* Involvement with other mental health agencies
* Incidences of violence
* Recent suicide attempts (last 2 years)
* Psychiatric intervention (last 2 years)

**Further details:*** Drug or alcohol misuse
* Suicidal Ideation
* Self-harm (Historic or current)
* Self-Neglect
* Physical Health conditions
* Social or domestic problems

**Further details:** |

**Consent to referral and contact by Gaddum**

* **This form will not be accepted without the consent of the person being referred**
* **For referrers:** If you are not with the patient/client at the point of referral, please ensure that you have gained consent for them to be referred and for them to be contacted by gaddum – and select the appropriate option below.

**Direct consent by person being referred (if possible):**

Do you consent to this referral, and being contacted via any of the contact methods provided on this form (including receiving text appointment reminders)?

 **⃣** Yes ⃣ No

**If not, please let us know how you would like to be contacted below (please be aware that if we are unable to reach you within 10 working days of the referral your case may be closed):**

**Client signature:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**OR**

**Consent gained by referrer:**

Does the person being referred consent to the referral and consent to being contacted via any of the contact methods provided on this form (including text appointment reminders)?

 **⃣** Yes ⃣ No

**If not, please let us know how the patient/client would like to be contacted below (please be aware that if we are unable to reach them within 10 working days of the referral the case may be closed):**

**Please complete and return to** **referrals@gaddum.org.uk** **or post to**

**Therapy Services, Gaddum, 6 Great Jackson St, Manchester M15 4AX.**

**You can also call: 0161 834 6069 with any queries about our services.**