Professional Referral

\*Please complete all sections of the referral form. Any information missing may cause a delay in the referral process.

Please gain consent of individual prior to referring them to our service.

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| **Has the client consented to this referral? Yes /No** Consent to contact by: Telephone/Mobile: **Yes /No** |
| Consent to contact by Letter**: Yes /No** Can we say who we are by Text or voice message: **Yes /No** |
| Consent to be contacted by a volunteer: **Yes/No** |
| Any disability requirements? **Yes/No** Any literacy difficulties? **Yes/No** Interpreter required? **Yes/No** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Referrer’s details | | | | | | |
| Referral Date: | Your name (referrer):  Your organisation: | | | Job title and contact details: | | |
| Service user’s details | | | | | | |
| Forename: | Surname: | | | Gender: | DOB: | |
| Address:  Postcode: | | | | | NOTE: If **NFA**, ask *‘Are you in receipt of Benefits?’*  If Yes, use address which they claim from. | |
| Home Number Mobile Number Email: | | | | | | |
| Consent to contact GP: **Yes /No**  GP Surgery address | | Next of kin details  Name:  Relation to client: Contact Number: | | | | |
| ALCOHOL USE: **Yes /No**  *Specify how much and how often* | | | Please tick areas of concern:  ***Physical Health, Emotional Health, Family, Relationships, Housing, Work****,* ***Employment, Finances, Illegal Activities*.** | | | |
| DRUG USE**: Yes /No**  Specify drugs used and how | | | Please tick areas of concern:  **P*hysical Health, Emotional Health, Family, Relationships, Housing, Work, Employment, Finances, Illegal Activities*** | | | |
| IS CLIENT OR PARTNER PREGNANT (IF YES GIVE DUE DATE) | |  | | | |
| Current/history of mental health  Current/ history self-harm or suicidal thoughts/plans  Please specify | |  | | | |
| Does client **need** to be seen by a male or female worker?  Please specify | |  | | | |
| Other service involvement (Social Care, probation, CMHT, Health Visitor):  Please specify | |  | | | |
| Criminal Justice (current or past cautions)  Please specify | |  | | | |
| Any children which may be in need/Risk:  Please specify | |  | | | |
| Physical health conditions or symptoms which are likely to require treatment:  Please specify | |  | | | |
| Client may present harm to self or others(threatening behaviour, verbal aggression, physical aggression):  Please specify | |  | | | |
| ***Any other Information we need to know:*** | | | | | |

[Professional Referral - Inclusion Hants](https://www.inclusionhants.org/professional-referral/).

This form can be emailed to: [inclusionhants@mpft.nhs.uk](mailto:inclusionhants@mpft.nhs.uk)