REFERRAL FORM

**There are 2 pages to this form. All sections to be completed. Any extra information can be continued on a separate sheet. Please send completed forms to** **contact@graceaftercare.org****.**

**REFERRER DETAILS:** (please give your details here)

|  |  |
| --- | --- |
| **Name (or self):** | **Agency:** |
| **Address:** | **Tel No:** |

**PERSON REFERRED:** (details of person being referred)

|  |  |
| --- | --- |
| Marital Status:  | Address: |
| First Name: |  |
| Surname: | Town: | Postcode: |
| Age: | Date of Birth: / / | ☐ Male ☐ Female |
| Home Tel: | Mobile Tel: | Email: |

|  |  |
| --- | --- |
| **GP Name & Address:** | **Medication** (deemed relevant): |

|  |
| --- |
| **Current issue to be supported:** |

|  |  |  |
| --- | --- | --- |
| **Contact with Mental Health Services** | ☐ YES | ☐ NO |
| **Contact with EDADS** | ☐ YES | ☐ NO |
| **Contact with other service** | ☐ YES | ☐ NO |
| If yes, please name |   |

**RISK ASSESSMENT**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **If YES, please describe** |
| Mental Health Issues | ☐ | ☐ |  |
| Suicide Risk / Self Harm | ☐ | ☐ |  |
| Violence / Harm to Others | ☐ | ☐ |  |
| Offending (past or present) | ☐ | ☐ |  |
| Child Protection | ☐ | ☐ |  |
| Other Risks Identified | ☐ | ☐ |  |
| **Current Social Circumstances** (eg. Relationships, living alone, support network) |

**OTHER AGENCIES INVOLVED:**

 ☐ GP ☐ Probation ☐ Social Services ☐ Hospital

 ☐ Prison ☐ Voluntary Agency ☐ AA/NA ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Why is this person involved with you service?** |
| **Why are you referring to our service?** |
| **Any other relevant information:** |

**ETHNIC GROUP:**

 ☐ White Scottish ☐ White Other British ☐ White Irish ☐ White Other

 ☐ Asian Bangladeshi ☐ Asian Chinese ☐ Asian Indian ☐ Asian Pakistani

 ☐ Asian Other ☐ Black African ☐ Black Caribbean ☐ Black Other

 ☐ Mixed Background ☐ Not Supplied ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referrer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Consent to be contacted by Phone/E-Mail** (optional)

Should the referrer wish GRACE to contact them by telephone or email to arrange their first appointment, please confirm telephone number and email address to be used and obtain client signature.

Telephone number: E-Mail:

Client Signature: Date: / / 