CONFIDENTIAL

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.

AGENCY DETAILS: (only complete if you are the referring agency)	
Referrer name:	**Referral agency:**
Agency address:	**Agency email/phone:**
Why is this person involved with you service?	
Why are you referring to our service?	
Any other relevant information:	

PERSON REFERRED (or SELF): (details of person being referred)

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

Emergency contact	Name:
Phone:	Relationship:

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

Current issue to be supported:

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Contact with Mental Health Services	☐ YES	☐ NO
Contact with ADRS	☐ 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, homelessness)			

OTHER AGENCIES INVOLVED:

☐ GP ☐ Probation ☐ Social Services ☐ Hospital

☐ Prison ☐ Voluntary Agency ☐ AA/NA ☐ Other _____

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 (or self): _____ Date: _____

Client consent to telephone/email contact (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: Email:

Client signature: Date: