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| --- | --- | --- | --- |
|  | **C:\Users\user\Downloads\AFF540DC.Unpacker_v7353qx4kg3sa!App\send.rar\send\MIND_Birmingham_Stack_Transparent.png** |  |  |

**Mental Health Wellbeing & Hub Service – Referral Form**

**SELF REFERRAL Y/N THIRD PARTY REFERRAL Y/N**

|  |  |  |
| --- | --- | --- |
| **Contact details** | | |
| Name: |  | |
| Date of Birth: | NHS Number: | |
| Address: |  | Postcode: |
| Contact Number: |  | |
| Email: |  | |

|  |  |
| --- | --- |
| **Referral Reason** | |
| **Eligibility criteria: 18+, under secondary mental health services in Birmingham or Solihull, on GP SMI list or having long term/severe mental health problems.**  Reason for referral – identified goals. i.e. :  Volunteering/pre-employment support  Mental Health or wellbeing management  Other – please give brief details  Description of mental health condition: | |
| **Please state which Hub preference (can access more than one Hub)**  **Yardley 🔾 Northfield 🔾 Erdington 🔾 Handsworth 🔾** | |
|  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Mental Health Team** | | | | | |
|  | | | | | |
| BSMHFT: ⃝ EI: ⃝ FTB CORE: ⃝ FTB EI: ⃝ OTHER ⃝ | | | | | |
| **Name & location of Mental Health Team:** | | |  | | |
|  | | | | | |
| **Key Mental Health Professional’s Details (CPN/GP/OT)** | | | | | |
|  | | | | | |
| Name: |  | | | | |
| Role: | Tel No. | | | | |
|  | | | | | |
| GP Details | | | | Emergency Contact | |
| GP Name: | |  | | Name: |  |
| Surgery Name: | |  | | Relationship: |  |
| Tel. No: | |  | | Tel. No: |  |
| Named Carer: | |  | | Address: |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Disability Information** | | | | | | | | | |
|  | | | | | | | | | |
| Learning Disability: | | | Yes: |  | No: |  |  | | |
| Physical Disability: | | | Yes: |  | No: |  |
| Please let us know whether there are any additional support required regarding physical difficulties or disabilities to attend the appointment, and/or whether there are any specific communication requirements: | | | | | | | | | |
| **Additional Support Requirements** | | | | | | | | | |
| Please let us know, below, whether there are any additional supports required for attending the appointment with us: | | | | | | | | | |
| Language Support: |  | Interpreter: | | | | | |  |  |
|  | | | | | | | | | |
| To be accompanied by a friend/carer: |  | Appointment on a specific day: | | | | | |  |  |
|  | | | | | | | | | |
| Appointment at a specific time: |  | Appointment at a specific location: | | | | | |  |  |
|  | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
| Please provide any further relevant information here: | | | | | | | | | |

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| --- |
| **Risk Information** |
| We do require information regarding any risk around your health and wellbeing. We may contact a key mental health professional for this information but please supply as much information as you can below: |
| |  |  |  |  | | --- | --- | --- | --- | | **Risks** | **Yes/No** | **Historical/**  **Current** | **Notes/Detail** | | Self-harm/Suicide |  |  |  | | Self-neglect |  |  |  | | Harm to others/from others |  |  |  | | Substance misuse |  |  |  | | Forensic History |  |  |  | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Consent** | | | | | | | | |
| Please confirm below that consent is given or has been sought and gained, for the following: | | | | | | | | |
|  | | | | | | | | |
| The person being referred has consented to this referral: | | | Yes: | |  | No: |  |  |
|  | | | | | | | | |
| The person being referred has consented to sharing their information: | | | Yes: | |  | No: |  |  |
|  | | | | | | | | |
| Name: |  | Date: | |  | | | | |
| Signature: |  | | | | | | | |
|  | | | | | | | | |

**Please return this completed referral form to:**

[**MHWH@BIRMINGHAMMIND.ORG**](mailto:MHWH@BIRMINGHAMMIND.ORG)

**VISIT WEBSITE:** [**www.birminghammentalhealth.org.uk**](http://www.birminghammentalhealth.org.uk)

**Telephone Enquiries: 0121 608 8001**