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**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: |  |

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| --- |
| **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 supportMental Health or wellbeing managementOther – please give brief detailsDescription of mental health condition:  |
| **Please state which Hub preference (can access more than one Hub)****Yardley 🔾 Northfield 🔾 Erdington 🔾 Handsworth 🔾** |
|  |  |

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| **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: |

|  |
| --- |
| **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 |  |  |  |

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| --- |
| **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**

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

**Telephone Enquiries: 0121 608 8001**