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| **REFERRER INFORMATION** | |
| **Referral Completed by:** | **Date of referral:** |
| **Contact Details:** (*Please provide preferred communication method to receive patient updates and information)* | **Profession:** |
| **Service User GP surgery:** | **PCN:**  **Hub Locality:** |

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| **SERVICE USER DETAILS** | | | |
| **Title:** | **Forename:** | **Surname:** | **Date of Birth:** |
| **Address & Postcode:** | | **Home Telephone:**  **Mobile Number:** | **Interpreter required?**  YES  NO |
| **Gender Identity:**  Male  Female  Transgender Male  Transgender Female  Agender  Gender fluid  Prefer not to say  Other (please specify): | | **Sexual Identity:**  Heterosexual  Bisexual  Homosexual  Pansexual  Asexual  Prefer not to say  Other (please specify): | |
| **Ethnic Origin:**  White British  White-Irish  Other White  Black/Black British – Caribbean  Black/Black British – African  Black/Black British - other  Asian/Asian British Indian  Asian/Asian British Pakistani  Asian Other  Chinese  Mixed other  Other (please specify): | | **Disability**  Behavioural and Emotional  Hearing  Learning Disability  Cognitive  Mobility and Gross Motor  Sight  Speech  Personal self-care  Physical Health  No Disability  Other (please specify): | |
| **Disability: Please identify Disability**  Behavioral and Emotional  Hearing  Learning Disability  Manual Dexterity  Mobile and Gross Motor ☐ Sight ☐ Speech ☐ Perception of physical danger  Personal self-care and continence  Progressive conditions and Physical Health  No Disability  Other (please state): | | | |

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| **Peer Navigation** |
| **Support required:**  Accommodation  Employment/ Training Education  Money management  Council Tax/Benefits  Finding meaningful activity  Health Advice  Making friends  Family/peer relationships  Take an active role in their health and wellbeing  LGBTQI+  Other (please state): |
| **What would the service user like to achieve?** |
| **Risk Management** |
| **Who does the service user live with:**  Alone  With Spouse/partner  With Family  In Residential Accommodation  Prefer not to say Care Leaver  In Care Other(Please state):  **Does the service user have parental responsibility for children aged under 18?**  Yes  No  Declined to answer  **Do any of the children live with the service user?**  Yes  No  Other(Please state): |
| **Are there any Safeguarding concerns related to the service user?**  Yes  No  **If yes, please provide details** |
| **Does the service user display any behaviour which can increase risk to themselves or others?** |

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| **Processing and Disclosing Data:** |
| I understand that Rethink Mental Illness may be required to provide my personal data to the public body which commissions Rethink Mental Illness services.  I confirm staff have discussed with me the circumstances when and the reasons why they may have to disclose personal data without my consent.  I am happy for Rethink Mental Illness may use my personal data, including concerning my health, to undertake evaluation and research in order to help plan and improve services.  I give consent for Rethink Mental Illness to use my personal data as explained in this form, and to share the following data with the following agencies or individuals. |
| **Has the person provided consent to be referred to Rethink Mental Illness?**  Yes  No |