**DATE OF REFERRAL:**

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| **PERSONAL DETAILS**  |
| **Title:** | **Forename:** | **Surname:** | **Date of Birth:** |
| **Address & Postcode:** | **GP Name & Address:** | **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): |
| **Are you in care or a care or a care leaver?** *(If yes, please specify which)*No [ ]  Yes [ ]  |
| **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): |

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| **Your Support** |
| *Please tick what you need support with from the following:*Accommodation [ ]  Employment/ Training[ ]  Education [ ]  Money management [ ]   Council Tax/Benefits [ ]  Finding meaningful activity [ ]  Health Advice [ ]  Making friends [ ] Family/peer relationships [ ]  Take an active role in my health and wellbeing [ ]  LGBTQI+ [ ] Other (please state): |

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| *Tell us more about yourself and what you would like to achieve with us.* |

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| **Risk Management**  *Please give us as much information as possible.* |
| **Have you ever had thoughts of self-harm?** |
| **Are you currently self-harming?** |
| **Do you have thoughts of ending your life?** |
| **Who do you live with?**Alone ☐ With Friends [ ]  With Spouse/partner ☐ With Family ☐ In student Accommodation ☐ Foster parent [ ]  Prefer not to say ☐ Other (Please specify): |
| **Do you have parental responsibility for children under the age of 18?**Yes [ ] No[ ] Decline to answer [ ]  | **Do any of the children live with you?**Yes [ ] No[ ] Other (Please Specify): |

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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. |
| **Are you happy to proceed with this referral to Rethink Mental illness?**Yes [ ]  No [ ]  |