Apr 2018

mind in Croydon
for better mental health

Employment Support

Employment Support
PRIMARY CARE REFERRAL FORM

Supporting people to increase their mental wellbeing through social inclusion and employment.

Please only use this referral form if the client is accessing primary care, eg referrals from GP's, IAPTS and Social Worker

This referral form must be completed by the health professional. It is recommended that this referral form is completed with the client present or at least with their given consent. As clients have access to their notes, please state if there is any reason why this referral form should not be shown to them.

Terms and conditions:

1. Clients must be aged over 18, have an understanding of their mental health and show a willingness to respect the confidentiality and dignity of all staff, volunteers and service users.
2. The service must be informed should the client relapse to a level where they are unable to attend the service.
3. The service reserves the right to refuse or discontinue a client's placement with the service if they are in breach of their agreement or if the service is deemed inappropriate to the client.

CLIENT DETAILS

Title: Mr/Mrs/Miss/Ms (delete as appropriate)	
Surname:	First name:
Address:	
	Postcode:
Tel number:	Mobile number:
Email address:	
Preferred contact:	
Date of birth:	National insurance:
Next of Kin/Person available in the event of an emergency: Name: Relationship: Contact:	

REFERRER DETAILS

Surname:	First Name:
Agency:	Team:
Postion:	
	Postcode:
Email address:	
Tel number(s):	*Practice/Surgery Stamp*
How are you involved in this persons' care?	

Does the client have a mental health diagnosis? ☐ Yes ☐ No

Please give a description and history of the client's mental health

Is the client prescribed any medication? Please give details including side effects.

Does the client have a history of violent, aggressive or sexually inappropriate behaviour?

Please give full detailed report

Are there any other risks we need to be aware of? ☐ Yes ☐ No

If yes please give details:

Do you know of any other factors that may affect the client's ability to access our services?

(For example physical health, sight or mobility)

Additional Information

Please give details of any other useful information. If you have any additional reports or letters that you feel would help us please attach copies when you return this form.

I declare that the details I have given on this form are accurate to the best of my knowledge.
This referral form needs to be signed by both parties.

REFERRER		CLIENT	
Signed	_____	Signed	_____
Dated	_____	Dated	_____
Print	_____	Print	_____

RETURN THIS FORM TO: Orchard House, 15A Purley Road, South Croydon, CR2 6EZ

In accordance with Data Protection Law, we will only use your personal data for those purposes for which you have given your permission. A full copy of our Privacy Statement is available at www.mindincroydon.org.uk