**Professional Referral form**

**Please complete all sections**.

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| **Date of referral:** |
| **Clients Details** |
| **Name:** |  |  |  |  |  | **Title:** |
| **DOB:** |  |  |  |  |  |  |
| **Address:** |  |  |  |  | **GP:** |
|  |  |  |  |  |  | **GP Surgery:** |
|  |  |  |  |  |  | **Address:** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Post Code:** |  |  |  |  | **Post Code:** |
| **Preferred Telephone Contact Number:** | **Can we leave a voicemail?** Yes / No**Can we send a text?** Yes / No**Can we email** ? Yes/No |
| **Email address:**  |  |
| *(if known and consent to being used)* |
| **Is the client aware of the referral and consent to their information being used?** (Tick X in box to the right to confirm)  | [ ]  |
| **Gender Identity***Delete as appropriate* | Male\* / Female\* / Non-binary / Other / Not disclosed \**including transgender* | **Is this the same as birth** | Yes / No |
| **Ethnicity:** |  |
| **Refugee/Asylum Status:** | **Destitute Asylum Seeker / Asylum Seeker / Refugee / Not applicable**   |
| *Delete as appropriate* |
| **Interpreter Required:**  | Yes / No | If yes, please specify language: |
| **Special Requirements:** | Yes / No | If yes, please specify: |
| **Initially we send appointment letters/emails in English.** If this is unsuitable, please advise of the best way to contact your patient: |
|  |
| **Pregnant or been pregnant in the last 12 months?** | Yes / No |
| **Is the client’s partner pregnant or been pregnant in the last 12 months?** | Yes / No |
| **Is the client a main caregiver of a child under 5 years old?** | Yes / No |

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| **Referrers Details**  |
| **Name:** | **Job title:** |
| **Address:** | **Tel number:** |
|  |  |
|  | **Email address:**  |

**Lets-talk is not an immediate support service. If the patient needs immediate support, please refer them to careline**

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| **Mental health information** |
| **Is the client currently under the care of a service?** | Yes / No |
| **Does the client have an open referral with another mental health service?** | Yes / No |
| **If yes, please indicate which team:** |
| Community Mental Health Team (CMHT) [ ]  Crisis [ ]   |
| Other mental health service (*please specify*): |
| **Does the client have a diagnosis of any Mental Health:** |
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| **Please provide a brief reason for referring this client:** |
|
| **Advocacy** | **Employability / educational** | **Support Services** | **Emotional/practical support** | **Activities / social inclusion**  |
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***Please email the completed form to*** ***Admin@lets-talk.today***