**Professional Referral form**

**Please complete all sections**.

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

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

|  |  |
| --- | --- |
| **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:** | |
|  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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***](mailto:Admin@lets-talk.today)