**My Practice, My Health Referral Form**

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| --- | --- |
| **Referring professional details** | |
| Name: | Team: |
| Location where you support the client: | Contact Number: |
| Role: | Email address: |
| **Consent** | |
| Do you consent to us processing your referral and storing it on our system?  Yes ☐  No ☐ | |
| **GP Details**  Name:  Address:  Telephone Number: | |
| **Patient details** | |
| Title: Miss | Full name: |
| Date of birth: | Mobile no: |
| Address: | Landline no: |
| Postcode: | Email: |
| Mental health conditions: | Physical health conditions: |
| Can client be seen alone?  Yes ☐  No  ☐    Does the client have any dependents?    Yes ☐  No ☐  If yes, how many dependents does the client have?  How old is each dependent? | Urgency of Case:  Critical (tick if there is a high risk or immediate deadline)  ☐  High ☐  Medium ☐  Low  ☐ |
| In the space below, please briefly summarise the state of the client’s mental health at the time of referral and any risk factor that the team should be aware of: | |
|  | |
| **Support Needs** | |
| *Please detail any support or communication needs staff will need to provide a service e.g. spoken language, British Sign Language, Makaton, Pictures, Gestures / Facial Expressions /Vocalisations:* | |

**Equal Opportunities**

**If you have completed this referral on behalf of someone else due limited communication or lacking capacity around these questions, please indicate:**

Yes ☐   
No  ☐

|  |  |
| --- | --- |
| **I identify as:** | **How would you describe your sexuality:** |
| Prefer not to say ☐  Male ☐  Female ☐  Non-Binary ☐  Transgender ☐  Other ☐ | Prefer not to say ☐  Lesbian ☐  Gay ☐  Heterosexual ☐  Bisexual ☐  Questioning ☐  Not known ☐  Other ☐ |
| **Please describe your religious beliefs:** | **Do you consider yourself to have any of the follow:** |
| Prefer not to say ☐  Buddhist ☐  Christian ☐  Sikh ☐  Hindu ☐  Muslim ☐  Jewish ☐  Any other religion ☐  No religion ☐  Not known ☐ | Prefer not to say ☐  Mental ill health ☐  Physical disability ☐  Cognitive impairment ☐  An acquired brain injury ☐  An acquired brain injury ☐  A learning disability ☐  Asperger’s/Autistic Spectrum ☐  Dementia/Alzheimer’s ☐  Sensory impairment ☐  Not known ☐ |
| **Please describe your ethnic origin/background:** | |
| Prefers not to say ☐  Ethnicity not known ☐ | **Other Ethnic Group:**  Arab ☐  Any other ethnic group (specify) ☐ |
| **White:**  English/Welsh/Scottish/Northern Irish ☐  Irish ☐  Irish Traveller or Gypsy ☐  Any other white background (please specify) ☐ | **Mixed Ethnic Groups:**  White and Black Caribbean ☐  White and Black African ☐  White and Asian ☐  Any other mixed background (please specify) ☐ |
| **Asian/Asian British:**  Indian ☐  Pakistani ☐  Bangladeshi ☐  Chinese ☐  Any other Asian background (please specify) ☐ | **Black/Black British**  African ☐  Caribbean ☐  Any other Black/African/Caribbean background (specify) ☐ |