**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  ☐

|  |  |
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| **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) ☐  |