**Community Advice Links and Mental Health Support Service**

**PROFESSIONAL / SELF REFERRAL FORM (CALMHS)**

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| **1.** | **Date of referral:** |  |

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| **2.** | **Client Name:** |  |
| **Date of Birth:** |  |
| **NHS Number:** *(Mandatory)* |  |
| **Address:** |  |
| **E-Mail:** |  |
| **Contact Telephone Number:** |  |
| **Mobile Telephone Number:** |  |
| **Preferred method of contact:** |  |

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| **3.** | **G.P. Name:** |  |
| **Surgery:** |  |
| **Address:** |  |
| **Contact Telephone Number:** |  |

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| **SECTION 4 TO BE COMPLETED BY PROFESSIONALS ONLY** | | |
| **4.** | **Referrers Name:** |  |
| **Team & Address:** |  |
| **Contact Telephone Number:** |  |
| **Contact E-mail:** |  |

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| **5.** | **Current Mental Health diagnosis?** *(e.g. anxiety, depression, stress, ASC)* |
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| **6.** | **Tell us a bit about Mental Health History** *(Please include any support from Secondary / Primary Services and any interventions engaged in.)* |
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| **7.** | **Have there been any episodes of violence/anger/challenging behaviour in the past 2 years?**  *(Please give as much detail as possible.)* |
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| **8.** | **Any other health issues that we need to be aware of?** |
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| **9.** | **Reason for Referral:** *(Please state what the client is interested in doing e.g. community groups/activities/adult education/voluntary work/paid work/engagement in local area etc. Please also state what the client’s aspirations/goals are. Please be as detailed as possible in all relevant sections.)* |
| 1. **Aims, goals and objectives for reference / engagement with Independence Trust** |
| 1. **What does the client hope to achieve while with Independence Trust?** |
| 1. **What hobbies are they / you interested in etc.** |
| 1. **Are they / you interested in any of the following?**   **Groups**  **Community Activities**  **Adult Education**  **Voluntary Work**  **Paid Work**  **Exposure Work** |
| 1. **Are there any mobility / accessibility issues we need to be aware of? If yes, what is needed? Yes  No** |

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| **10.** | **For SELF REFERRALS, how did you hear about our service?** |
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| **SECTION 10 TO BE COMPLETED BY PROFESSIONALS ONLY** | | | | |
| **11.** | **How long will you continue to work with the Client?** *(please indicate with X)* | | | |
| 4 weeks | 8 weeks | 12 weeks | 12 weeks + |
|  | **Comments** | | | |

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| **SECTION 11 TO BE COMPLETED BY PROFESSIONALS ONLY** | |
| **12.** | **Please include Current Care Plan with the referral** |
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| **SECTION 12 TO BE COMPLETED BY PROFESSIONALS ONLY** | | |
| **13.** | **Are you including a copy of the Risk Assessment?** *(please indicate with X)* | |
| Yes | No |
| **If no, why not?** | |

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| **BELOW FOR PROFESSIONAL REFERRALS ONLY** |

**The Service User has agreed to information sharing including risk and crisis plan?**

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| **Yes** | If ‘Yes’ please attach consent. |

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| **No** | If ‘No’, please call us to discuss how to proceed. |

**We the Referrer agree to update any relevant risk information and significant changes in care, including informing you when we discharge a patient whilst the Service User is engaged with Independence Trust.**

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| **Signature of referrer:** |  |
| **Please print name:** |  |

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| **Please forward your completed referral to:** |
| *Referral & Outcome Officer*  *Independence Trust, Community House, 15 College Green, Gloucester, GL1 2LZ* |
| **Or by email to:** |
| *info@independencetrust.co.uk* |