Mind for better mental health in Tower Hamlets and Newham

Date referral received:

Mind in Tower Hamlets and Newham
Mums Matter Referral Form

I understand that Mind in Tower Hamlets and Newham are required to share information with third parties in order to provide safe and effective care and agree for Mind in Tower Hamlets and Newham to share information in accordance with polices as outlined on the website; *http://www.mithn.org.uk/our-policy.html* [ ] yes [ ] No

Please complete all sections on this form if any do not apply please indicate with Not applicable

Individuals Contact Details

Title:		Full Name:
DOB:	Gender:	How did you hear of Mind in Tower Hamlets and Newham?
Address:		Landline number: Mobile number Email:
Is it Ok to leave an answerphone message? Y/ N		Preferred method of contact:
No of dependent children:		No of children under 5 years:
Do you have a Carer? ☐ Yes ☐ No		Do you have Carer responsibilities? ☐ Yes ☐ No

Reason For Referral

Please summarise below your reasons for making this referral; giving details, and what type of support you think would be helpful. Please also tell us what your ultimate outcome / goal is. To ensure that the support we offer will be useful to you, please give details of any diagnosis that you have received.

Risk details

Have you ever thought about suicide or acted on these thoughts? Yes / No	If you have answered 'yes' to any of these questions, please give details below.
Is there anything about your life which is unsafe to yourself or others? Yes / No	
Have you ever been violent or aggressive towards others? Yes / No	
Are you on; Probation, licence or have you ever been subject to conditions under MAPPA? Yes / No	

GP details	Social Worker details	Health Visitor details
GP Name: Surgery: Location: Contact Number:	Social Worker Name: Contact Number:	Health Visitor Name: Contact Number:

Preferred service:	Preferred Location:

Referrer Details

Self-Referral ☐	Professional referral ☐	
Completed by the individual ☐	Name:	Relationship:
Completed by MiTHN staff ☐ Staff name (if taken over the phone):	Organisation:	Contact Number/email:
	Is the individual aware of this referral? Yes ☐ No ☐	

Support From Other Services

Please indicate whether there is currently any involvement with other agencies that are providing specific support Social Services etc. ☐ Yes ☐ No ☐ Not sure

Name:	Role:	Contact details:
Name:	Role:	Contact details:

Is there currently any involvement with a mental health professional from the NHS (psychiatrist, Care Coordinator, Support Worker etc.)? ☐ Yes ☐ No ☐ Not sure

If you answered yes to this question, please give details and include a copy of the most recent Care Plan with the referral

Name:	Role:	Contact details:

Which (if any) MiTHN services have you accessed in the past?	Which (if any) other relevant services have you accessed in the past?

Demographic information	Service Access Requirements
This section is not compulsory but we would be grateful if you could complete it. Any information you give will not affect your qualification for any services offered.	**Do you have any specific access requirements?** *(mobility issues, barriers to communication etc.)* **Please state:**

Ethnicity:

White British		White / Black Asian		Asian Other	
White Irish		Mixed Other		African	
White Other		Indian		Chinese	
White / Black Caribbean		Pakistani		Other	
White / Black African		Bangladeshi		Prefer not to state	

Date:		Name:		Signature:	

For Office Use Only

Referral Actions: Waiting list letter sent ☐ On database ☐	Date Actioned:
	Staff Member:

Date	Type of contact	Outcome
	Telephone ☐ Letter/ email ☐	Deadline for contact
	Telephone ☐ Letter/ email ☐	Date referral closed:

Is service appropriate for individual	Yes ☐ No ☐
Does this person require signposting to more relevant services/ support If you answered yes to this question, please confirm details	Yes ☐ No ☐

Completed by		Date	