Privacy policy

I hereby confirm my understanding of and acceptance of the following information;

Mind in Haringey will utilise the personal data I have provided in this form for the purposes detailed in our privacy policy which can be found at http://www.mindinharingey.org.uk/reportspolicies.asp

We only use personal information in the ways we need to and that is expected of us.

We will keep you up to date with our work including any relevant services, changes to your confirmed appointments, raising awareness, promoting understanding as well as our fundraising activities.

Do you agree to us using your data in this way? (please mark yes or no with an **x**) Yes
No

If you're happy for us to keep in touch, please let us know how you would like to hear from us

	Yes	No
Post	☐	☐
Phone	☐	☐
Email	☐	☐
Text	☐	☐

Signature……

If you wish to remove your agreement to our use of your data at any point please let us know by either in;

Writing: Mind in Haringey, Station House, 73c Stapleton Hall Road, London, N4 3QF

Email: admin@mih.org.uk

Tel: 020 8340 2474

☐

Referral To: **Psychosis Therapy Project** **Mind in Haringey** Station House 73C Stapleton Hall Road London N4 3QF or Email: psychosistherapyproject@gmail.com
Self-referral **Yes** **No** **If no, please indicate Referrer (name, job title and contact details)**

PTP Referral Form

Client Details:

Name: **Address:**	**Date of birth:** **Gender:** **Ethnic Background:**
Contact phone number: **Email:**	**Religion/Faith:**
How would you prefer to be contacted? **Phone** **Email** **Post**	**Your current employment status:** **Employed (FT/PT)** **Unemployed (on benefits ESA, PIP)** **Student**
Are you currently taking any medication? **If yes, please specify**	**Yes** **No**

Client Details continued:

Have you had counselling in the past? **If yes, please specify** **When?** **Where?** **For how long?**	**Yes** **No**
Reason for accessing the Psychosis Therapy Project at Mind in Haringey (please include psychiatric diagnosis, if any):	
Do you have any other disability/health problems?	
Any forensic history **If Yes, please specify**	**Yes** **No**

Name and address of Psychiatrist/GP:

Psychiatrist (if applicable): **GP:**
Name and address of CPN/Social Worker (if applicable):

Next of kin details:

Name & Relationship:	**Address:**
Contact Number:	

Confidentiality & data Protection:
All information held on this form will be kept confidentially in a locked cabinet and will only be shared within the guidelines of Mind in Haringey Confidentiality as laid down in the 1998 Data Protection Act.

Signature of client: _____ Date: _____

Signature of Referrer: _____ Date: _____