**Referral Form**

**Haringey Wellbeing Network**

We ask all our service users to complete this referral form. You will only have to do this once, no matter how many of our services you would like to access. By completing this referral form you agree and consent to sharing information with the Haringey Wellbeing Network and connected professionals. We will also use this information for health and safety purposes and to evaluate and improve our services. Information provided will remain confidential and will be held on computerised and paper-based systems, in accordance with the General Data Protection Regulation (GDPR). Further details can be found on our website: <http://www.mindinharingey.org.uk/reportspolicies.asp>

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| Please tick the box to indicate you understood and consent to this policy and have been fully informed about the referral being made:  **Yes, I understand and consent.**  For third party referrals: has the referred individual consented to this referral being made on their behalf?  **Yes, they have consented.** | | | | | | | | | | | | | |
| **About you** | | | | | | | | | | | | | |
| **Date today:** | Office use:  **Date received:** | | | | | | | | Office use:  **Assessment:** | | | | |
| **Before we start, we need to ask some questions to best establish how we can help you.** | | | | | | | | | | | | | |
| **Do you currently have a care co-ordinator?**  **Do you have an address or GP in Haringey?**    **Do you have any spent or unspent criminal convictions?**  If you answered yes, please provide some brief details. This is not a disqualifying question. | | | | | | | | | Yes  No  Yes  No  Yes  No | | | | |
| **Full name:** |  | | | | | | | | | | | | |
| **Age:** |  | | | Date of birth: | | | | |  | | | | |
| **Gender** | Male  Non-binary | Female  Intersex | | | | | | Transgender  Other | | | |  | Prefer not to say |
| **Mobile:**  **Landline:** |  | | **Email:** | | | | | |  | | | | |
| **Address:** |  | | | | | | | | | | | | |
| **GP Details:** | Name:  Address:  Contact Number:  Email: | | | | | | | | | | | | |
| **Please list any other professionals you are currently working with.**  **(eg: support worker)** | Name:  Address:  Contact Number:  Email: | | | | | | | | Name:  Address:  Contact Number:  Email: | | | | |
| **Have you ever been diagnosed with or sought treatment for any of the following mental health conditions?**  Tick all that apply. | Anxiety  Bipolar disorder  Borderline personality disorder  Depression | | | | | | | | Obsessive compulsive disorder  Post-traumatic stress disorder  Schizophrenia / psychosis  Other (please detail): | | | | |
| **Do you consider yourself to have a disability?**  Tick all that apply. | A specific learning difficulty  such as dyslexia, dyspraxia or AD(H)D  General learning disability (such as Down’s syndrome)  A social/communication impairment such as Asperger’s syndrome/other autistic spectrum disorder  A long standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease, or epilepsy  A physical impairment or mobility issues, such as difficulty using arms or using a wheelchair or crutches | | | | | | | | Deaf or serious hearing impairment  Blind or a serious visual impairment uncorrected by glasses  A disability, impairment or medical condition that is not listed above  Other (please detail):  No known disability  Prefer not to say | | | | |
| **Do you have any access needs that we should know about?** | Interpreter required  Mobility restricted (ground floor appointments only)  Reading/writing asssistance required  Other (please detail): | | | | | | | | | | | | |
| **Please briefly explain your current problems.**  (You will have an opportunity to expand in the assessment however if completed by a professional please provide detailed information). |  | | | | | | | | | | | | |
| **Which Haringey Wellbeing Network services would you like to use?** | Peer Support 1-2-1 (or)  Peer Support Groups  People with their own lived experience of mental health act as coaches for others, helping to support them through their week to week struggles. This service is available in either a one to one or group setting. (12 weeks).  Wellbeing Advocacy  This service has a more hands-on style offering interventions around mental health needs and advocacy needs. This could include speaking on your behalf to organisations you may be struggling with and/or deciding specific goals around wellbeing and creating support plans to achieve and sustain them. (12 weeks).  Wellbeing Activities  A range of activities designed to encourage wellbeing and support anyone looking to connect with a hobby and reduce isolation. (12 weeks to 16 weeks).  Social Prescribing  If we do not offer a service that you might need, we can help find that service in the community and support you in connecting with them. (3 appointments) | | | | | | | | | | | | |
| **Employment status:** | Employed | | | | Unemployed | | | | | | Student | | |
| **Are you a carer?** | Yes | | | | No | | | | | | Prefer not to say | | |
| **Are you a refugee or asylum seeker?** | Yes | | | | No | | | | | | Prefer not to say | | |
| **Ethnic origin:** | **Asian**  Indian  Pakistani  Bangladeshi  Chinese  Any other Asian background (please detail)  **Black**  African  Caribbean  Any other black background (please detail)  **Mixed / multiple ethnic groups**  White & Black Caribbean  White & Black African  White & Asian  Any other (please detail) | | | | | | | | **White**  English / Welsh / Scottish / Northern Irish  Irish  Gypsy or Irish Traveller  Any other white background (please detail)  **Other Ethnic Group**  Arab  Any other ethnic group (please detail) | | | | |
| **Religion or belief:** | Buddhist  Christian  Hindu  Jewish  Muslim | | | | | | | | | Sikh  Other (please detail):  No religion  Prefer not to say | | | |
| **Sexual orientation** | Asexual  Bisexual  Gay man  Gay woman / lesbian | | | | | | Heterosexual  Other (please detail):  Prefer not to say | | | | | | |
| **What is your marital status?** | Civil partnership  Cohabiting  Divorced  Married | | | | | | | | Separated  Single  Prefer not to say | | | | |
| **How did you find out about Haringey Wellbeing Network?** | Word of mouth (friends, family)  Just came in/live locally  I was referred here  Internet search  Other (please detail): | | | | | | | |  | | | | |
| **Referral completed by:** | GP  IAPT  Self  Voluntary Organisation  Wellbeing Clinic  Other (please detail): | | | | | | | | | | | | |
| **Professional**  **Name:** | | | | | | **Professional**  **Signature:** | | | | | | | |
| **Professional referral agency contact details :** | | | | | | | | | | | | | |

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| **Thank you for taking the time to complete this referral…** |
| **Please send completed form to:**  **Email:** [haringeywellbeingnetwork@mih.org.uk](mailto:haringeywellbeingnetwork@mih.org.uk)  **Address:** Haringey wellbeing Network Administrator, Station House, 73c Stapleton Hall Rd, London, N4 3QF.  **Enquiries**: 0208 340 2474 (option 1). |