 **MENTAL HEALTH ADVOCACY- REFERRAL FORM**

**Person’s contact details**

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| Self Referral: Yes/No |
| **Name:**  | **Date of Birth:**  |
| Address: Safe to contact home address Yes [ ]  No [ ]   |
| Landline: Safe to contact Landline Yes [ ]  No [ ]   | Mobile: Safe to contact mobile number Yes [ ]  No [ ]   |
| Email Address: |
| Languages Spoken :  |
| Immigration Status (if known):  |

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| --- |
| **GP Details (For Emergency Use Only)** |
| **GP Name** |  |
| **GP Address** |  |
| **GP telephone number** |  |

**Referrers Details (if applicable)**

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| --- |
| Referrers Name:  |
| Referrers Organisation:  |
| Email Address:  | Mobile:  |

**Reasons for Referral/ Other Relevant Information** (Please use a separate sheet if applicable)

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| Please indicate whether this person would present any risk to either staff members, public or self. e.g. substance misuse, self-harm, physically aggressive behaviour etc. |

**Information Sharing and Consent**

I agree for this information and the referral to proceed with Paiwand’s Mental Health Advocacy service and have informed the referee of this.

|  |  |
| --- | --- |
| Referrer’s Signature (if applicable) | Date: |

**Please email this referral to:**

Ramzia.akbari@paiwand.com

**or by post to the following address:**

**** Ground Floor, 11 High Street, Edgware, HA8 7EE

