A picture containing text, clipart

Description automatically generated

**REFERRAL FORM**

Please fill in this form as completely as possible and return it to Liverpool@jamesplace.org.uk

We cannot accept referrals for anyone receiving secondary mental health care or with complex drug and alcohol issues. We cannot accept referrals from anyone who is street homeless or has a severe and enduring mental health condition.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Details of referrer** | | | | | | | | | | | | | | | | | |
| Date of referral |  | | | | | | | | | | | | | | | | |
| Name of Referrer |  | | | | | | | | | | | | | | | | |
| Job Title |  | | | | | | | | | | | | | | | | |
| Place of Work |  | | | | | | | | | | | | | | | | |
| Phone number |  | | | | | | | | | | | | | | | | |
| Email address |  | | | | | | | | | | | | | | | | |
| Where did you hear about us? | | |  | | | | | | | | | | | | | | |
| **Details of who is being referred** | | | | | | | | | | | | | | | | | |
| Name:  Preferred Name: |  | | | | | | | | | | Date of Birth: | | | | | |  |
| Postal Address: |  | | | | | | | | | | Phone number 1:  Phone number 2: | | | | | |  |
| Email address |  | | | | | | | | | | | | | | | | |
| Ethnicity | Relationship Status | | | | Sexuality | | | | | Gender Identity | | | | | | Occupation | |
|  |  | | | |  | | | | |  | | | | | |  | |
| **Next of Kin Details** | | | | | | | | | | | | | | | | | |
| NOK Name: |  | | | | | NOK Relationship: | | | | | | | |  | | | |
| NOK Phone no. |  | | | | | NOK Email: | | | | | | | |  | | | |
| **GP Details – Please provide complete information** | | | | | | | | | | | | | | | | | |
| GP Name |  | | | | | Practice | | |  | | | | | | | | |
| GP Address |  | | | | | | | | | | | | | | | | |
| GP Phone Number |  | | | | | | | | | | | | | | | | |
| **Email (if available)** |  | | | | | | | | | | | | | | | | |
| **Other professional support ie support worker, nurse practitioner, psychiatrist** | | | | | | | | | | | | | | | | | |
| Name |  | | | | | | | | | | | Job Title | | | | | |
| Place of work |  | | | | | | | | | | | | | | | | |
| Phone Number |  | | | | | | Email | | | | | |  | | | | |
| **Details of suicidal crisis** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Does this man have a history of suicide attempts? | | | | | | | | | | | | | | | | | |
| Has this man been bereaved by suicide? | | | | | | | | | | | | | | | | | |
| Does this man have a disability? | | | | | | | | | | | | | | | | | |
| Are there any risks to us or others we need to be aware of? Give details. | |  | | | | | | | | | | | | | | | |
| Are there any safeguarding issues we need to be aware of? Give details. | |  | | | | | | | | | | | | | | | |
| Does this person have any additional support needs eg language | | | | | | | |  | | | | | | | | | | |
| Does this person consent to this referral? | | | | Is he aware of what James’ Place offers? | | | | | | | | | | | Does he have an identified supporter? | | |
| YES | | | | YES / NO | | | | | | | | | | | YES / NO | | |

**Are their current difficulties related to any of the following factors?**

|  |  |  |
| --- | --- | --- |
| Relationship breakdown | Yes | No |
| Gambling | Yes | No |
| Debt | Yes | No |
| University | Yes | No |
| Work | Yes | No |
| Sexuality | Yes | No |
| Legal Problems | Yes | No |
| Family Problems | Yes | No |
| Bereavement | Yes | No |
| Drug/Alcohol Misuse | Yes | No |

Email:- Liverpool@jamesplace.org.uk

Address:- James’ Place

50 Catharine Street

Liverpool

L8 7NG

Phone:- 0151 303 5757