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Community Support Service Referral Form

**Tel:** **01923 727356**

**Email:** **css@hertfordshiremind.org**



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|  |  |
| --- | --- |
| Date of referral: |   |
| Verbal consent obtained for referral (if being referred by an agency): |  Yes [ ]  No [ ]  |
| New/ previous referral:  | New [ ]  Previous [ ]  |
| Referral source: |   |
| Title:  | Forename:  | Surname:  |
| Address:  | D.O.B:  |
| Postcode:  | First language:  |
| Telephone number and time to call:Is it ok to leave a message? Yes [ ]  No [ ]  | Alternative number:Is it ok to leave a message? Yes [ ]  No [ ]  |
| Can we text you on your mobile? Yes [ ]  No [ ]  |
| Email:  |
| Are there any children under 18? Yes [ ]  No [ ]  | Do they live at home? Yes [ ]  No [ ]  |
| Name | Date of birth | Name | Date of birth |
|  |  |  |  |
|  |  |  |  |
| Agencies working with children: |  |
| Housing status: (Private rented, mortgage, Housing Association): |  |
| Names on tenancy agreement: |  |
| Name of Housing Association: |  |
| Other agencies involved (e.g. Children’s Services, Police, Mental Health, Housing, Others, etc.): |  |
| Description of areas of need and reason for referral *(please include relevant history and presenting needs)* |
| Does the client have any mental health needs? |
| Does the client have any physical health needs?  |
| Any additional notes: |
| Details of supporting documents sent with the referral (if applicable) *Please list*: |
| Referrers Name:  | Position:  |
| Client Name (if self referral) | Signature |

**Disclosure**

*We are required by the Data Protection Act 2003 to have the client’s consent for us to 1) request information from or share information with other services 2) keep a record of their support from Hertfordshire Mind Network. All information will be dealt with as per Hertfordshire Mind Network’s Data protection & Confidentiality Policy.*

**I confirm that the client has agreed to this information being passed to Hertfordshire Mind Network. The client understands that information may be passed to other agencies.**

Please check the box to consent to the above [ ]

**Client’s name:**  **Date:**

Referrals are occasionally received which may be deemed appropriate for one or more of our services. Please check this box if the client agrees to this referral being transferred internally if appropriate

*(the client and referrer will be informed in this instance)*.[ ]