Mind Havering, Barking and Dagenham

Mums Matter!

Date:

Type of referral (office only):

PLEASE SIGN DECLARATION IN BOLD BELOW

I understand that HBD Mind are required to share information with third parties in order to provide safe and effective care. I understand that HBD Mind will store this information securely and in line with the law, for no longer than necessary. I give permission for HBD Mind to share information in accordance with polices as outlined on the website: www.haveringmind.org.uk [ ] YES [ ] NO

Please complete all sections on this form, if any do not apply please indicate with N/A		
Individual Contact Details		
Title:	Full Name:	
D.O.B:	Gender:	Do you have access to internet:
Home address:		
Home Telephone:	Ok to leave a voicemail? Yes or No	
Work Telephone:	Ok to leave a voicemail? Yes or No	
Mobile Telephone:	Ok to leave a voicemail? Yes or No Ok to text? Yes or No	
Email Address:	Ok to Email? Yes or No	
Preferred method of contact: Phone call or Email (Please write below if preferred method of contact is alternative address for correspondence)		
Next of Kin or Emergency Contact: (Please provide a name and phone number)		
GP Name:		Surgery Name:
Surgery Address:		Surgery Telephone:

<table>
<tr><td>Number of children:</td><td>Ages of children:</td></tr>
<tr><td colspan="2">Do you have any specific access requirements (mobility issues, barriers to communication etc.):</td></tr>
<tr><th colspan="2">Risk Details</th></tr>
<tr><td>Is there anything about your life which is unsafe to yourself or others?

Yes/No</td><td>If you have answered ‘yes’, please give details below:</td></tr>
<tr><th colspan="2">Reason for Referral</th></tr>
<tr><td colspan="2">Please summarise below your reasons for making this referral, including the type of support you think would be helpful to you, and your expectations of the service:

To ensure that the support we offer will be useful to you, please give details of any mental health diagnosis that you may have received or any mental health service that you have accessed in the past:

Are you currently accessing any mental health services:</td></tr>
<tr><th colspan="2">Referrer Details</th></tr>
<tr><td colspan="2">Please circle: Self-referral Completed by other</td></tr>
<tr><td colspan="2">Name of referrer:</td></tr>
<tr><td colspan="2">Contact of referrer:</td></tr>
<tr><td colspan="2">Organisation of referrer:</td></tr>
<tr><th colspan="2">Ethnicity</th></tr>
</table>

White British		White/Asian		Asian Other (Please specify)	
White Irish		Mixed Other (Please specify)		Black African	
White Other (Please specify)		Indian		Black Caribbean	
White/Black Caribbean		Pakistani		Other (Please specify)	
White/Black African		Bangladeshi		Prefer not to state	

Other	
Please provide any other information that you think may be relevant:	
Form completed by name and signature:	

Once completed, please return to mumsmatter@haveringmind.org.uk