|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Referral form (CNWL to fill in) | | | | | |
| Date/time of referral\* |  | | | | |
| Referring for\* |  | | | | |
| State whether they are receiving any support at the moment and what has triggered the current episode |  | | | | |
| Reason for referral and how can the Coves support the referred individual?\* |  | | | | |
| Diagnoses (ICD-10) |  | | | | |
| Current Medications |  | | | | |
| Name of referred individual \* |  | | | | |
| NHS Number\* |  | | | | |
| DOB\* |  | | | | |
| Contact details for the referred individual\* | Tel:  Email: | | | | |
| Address and postcode of referred individual\* |  | | | | |
| Borough\* |  | | | | |
| Next of Kin / Emergency Contact | Name |  | | | |
| Contact Details |
| Referrer team | *Please specify which team e.g. St Mary’s A&E LPS / Harrow MHEC / Westminster HTT* | | | | |
| Referrer’s name and contact details\* | Name |  | | | |
| Phone /Email |  | | | |
| Individual Primary Language\* | Main spoken language English | | Other Language(s) | |  |
| Any known disability / Health condition | |  | | | |
|  | |  | | | |
| **Please confirm consent has been obtained from the service user\*** | |  | | | |
| Any special requirements | |  | |  | |
| Accessibility information | |  | | | |
| **CNWL Risk Information** | | | | | |
| Risk to or from self/others  Any known risk of self-injury, suicidal ideation, behaviour issues | **Details:** | | | | |
| Risk of neglect / vulnerability: | **Details:** | | | | |
| Any safeguarding concerns and actions taken |  | | | | |
| Additional information |  | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Coves Outcome (Hestia staff to complete)** | | | | | |
| Date/time |  |  | | |  |
| Name of referred individual |  | NHS number | | |  |
| Did individual attend for appointment | Yes | | | | |
| Session | Digital Extension / first / Second / Final | | | | |
| Details of DNA/attendance e.g. reason given, nature of presentation, change in mood |  | | | | |
| Duration of visit (hours) |  | | | | |
| Demographics | Religion | | |  | |
| Gender | | |  | |
| Ethnic Group | | |  | |
| Any Disability | | |  | |
| Sexual Orientation | | |  | |
| Country of Origin | | |  | |
| Are you currently under the care of the CNWL Trust?  (Yes / No, and specify) | (*You would be considered under the care of the Trust if you are currently receiving ongoing care/support from any of the following:  HTT, CMHT (i.e. do you have a Care Coordinator?) or if you have a Psychiatrist attached to any hospital or service.  Note: attendance at the Recovery College does not constitute under the care of the Trust.)*  ***Please Specify:*** | | | | |
| Activities and Interventions undertaken | Safety Plan | |  | | |
| WRAP | |  | | |
| Social Prescribing | |  | | |
| Peer activity | |  | | |
| Signposting | |  | | |
| Correspondence / engagement with MH professionals | |  | | |
| Other (please specify) | |  | | |
| Details of support activity indicated above |  | | | | |
| Other information including new risk management concerns identified |  | | | | |
| Follow up recommendations |  | | | | |
| On a scale of 1-10 (1 being very unhelpful and 10 being very helpful), how useful/supported did you find the session? | | | | | |
| Did the service help you feel less anxious? | | | | | |
| Did the service help you know what to do to manage your own wellbeing? | | | | | |
| Date:  Completed by:  Checked by: | | | | | |