|  |
| --- |
| 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/othersAny 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: |