Young Adult Mental Health Program

Referral Form



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| **REFERRAL CRITERIA**

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| * The young person is aged 16-25
* The young person lives, works, or attends school/college/university in Hillingdon OR is registered with a Hillingdon GP
* The young person requires referral/signposting, guidance, or peer mentoring to support their social, emotional, or mental health
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| Data protection and confidentialityIn order to receive a service, some of the information you submit will be shared with the registered GP and may also be shared with other relevant NHS services. The data provided will be stored on Hillingdon Mind computer file system. This will be explained further during the initial contact. |
|  ***All fields are mandatory*** |
| **PERSONAL DETAILS** |
| **Surname:** | **First Name:** | **NHS No:** *(state if unknown)* | **Date of birth:** |
|  |  |  |  |
| **Address & Postcode:** | **Telephone:** *(Home/Mobile)* | **Email:** *(state if unknown)* |
|  |  |  |
| **Main Language:** | **Interpreter Required:** | **Parent/Carer Details:** *(if applicable)* |
|  | Yes [ ] No [ ]   |  |
| **Gender:** | **Ethnic Origin:** | **Religion:** | **Disability:** |
| Male [ ]  Female [ ] Other (please state): | White British [ ]  White Other [ ]  Black/Black British [ ]  Asian/Asian British [ ]  Chinese [ ]  Mixed [ ]  Other (please state): | Christian [ ]  Hindu [ ]  Jewish [ ]  Muslim [ ]  Sikh [ ] Other (please state): | Autism Spectrum Condition (ASC) [ ]  ADHD [ ]  Learning Disability [ ]  Physical Disability [ ]  Speech & Language [ ]  Other (please state): |
| **Registered GP:** *(Name & address of Practice)* | **School/College/University Details:** *(if applicable)* |
|  |  |
| **Social Care Status:** | **Education/Employment:** |
| CIN [ ]  CP [ ]  LAC [ ]  No involvement / other (please state):  | Attends school/college/university [ ]  Employed full/part-time [ ]  Apprenticeship/vocational training [ ]  Not in education or employment [ ]   |
| **REFERRAL DETAILS** |
| **Presenting issues/difficulties:** | **What are you/the young person hoping to gain from this referral:** |
|  |  |
| **Are any other professionals involved in the young person’s care?** |
| Yes [ ]  No [ ]   | *If yes, please detail:* |
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| **RISK SUMMARY** |
| **Risk to self:** *(e.g., self-harm, suicidality,* *substance use)* | Yes [ ]  No [ ]   | *If yes, please detail:* |
| **Risk to others:**  | Yes [ ]  No [ ]   | *If yes, please detail:* |
| **Risk from others:**  | Yes [ ]  No [ ]   | *If yes, please detail:* |
| **Other risks:** *(if applicable)* |  |
| **REFERRER DETAILS** |
| **Has the young person consented to this referral?** | Yes [ ]  No [ ]   |
| **Referrer Name:** |  | **Email:** |  |
| **Role and Organisation:** |  | **Telephone:** |  |
| **Address:** | **Signature:** | **Date:** |
|  |  |  |