Young Adult Mental Health Program

Referral Form



|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REFERRAL CRITERIA**   |  |  | | --- | --- | | * 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 |  | | | | | | | | | |
| Data protection and confidentiality  In 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:** |
|  | | | | | | |  |  |