**Gwent Mental Health Consortium**

**Referral/Contact Form**

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| For Referrals please forward completed forms to: **Gwent Mental Health Consortium** **Tel:** 01633 810718 **Email:**  info@growingspace.org.ukBy submitting this referral (either as an individual or an agency with the consent of an individual), consent is being given for the storing and sharing of information with partner agencies:* The sharing of information with Consortium partners
* The storage of information in line with data protection regulation.
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| **Personal Details** |
| Mr [ ]  Mrs [ ]  Miss [ ]  Ms [ ]  (tick appropriate)  |
| Full Name: Click here to enter text. |
| Date of Birth: Click here to enter text. |
| Address: Click here to enter text. |
| Postcode: Click here to enter text. |
| Tel:Click here to enter text. | Mobile: Click here to enter text. | Email:Click here to enter text. |
| **Emergency Contact Details** |
| Name: Click here to enter text. |
| Address Click here to enter text. |
| Postcode: Click here to enter text. |
| Telephone number: Click here to enter text. |
| **GP Details (for counselling referrals)** |
| G.P Name: Click here to enter text. |
| Surgery address: Click here to enter text. |
| Telephone Number: Click here to enter text. |
| **Which Local Authority area do you live in? (please indicate)** |
| Newport [ ]  | Torfaen [ ]  | Blaenau Gwent[ ]   | Caerphilly [ ]  | Monmouthshire[ ]   |

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| Please can you describe your mental health issues and/or caring role.  |
| Click here to enter text. |
| Please can you describe the support required in relation to your needs. |
| Click here to enter text. |
| Please detail any existing support you are receiving. |
| Click here to enter text. |
| Your referral will be passed to the Information, Advice and Assistance staff in your area who will contact you to discuss your needs. |

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| **Referrer** | **Contact Details: (Name Address Telephone)** |
| Health Secondary Services (CMHT) | Click here to enter text. |
| Health Primary Care (PCMHSS) | Click here to enter text. |
| Third Sector Organisation | Click here to enter text. |
| G.P | Click here to enter text. |
| Self-Referral | Click here to enter text. |
| Other Organisation (please state) | Click here to enter text. |

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| Are there any risk issues that we need to be aware of? (for example; risks to yourself or to others)Click here to enter text. |

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| Do you have a drug, alcohol or substance misuse problem? Yes [ ]  No [ ]  Prefer not to say [ ] If yes please say a little bit more about the problem, such as which substance or drug and how long you have had the problem. Click here to enter text. |

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| Any Other Information? Click here to enter text. |
| **Consent**By submitting this referral/contact form, consent is being given for the:* Sharing of information with Consortium partners
* The storage of information in line with data protection regulations.

 For more information about how we collect, use, protect and store your information please see a full copy of our privacy notice which is available to you and can be accessed via our website:www.gwentmentalhealthconsortium.org |
| Date of Referral: Click here to enter a date. |

**Equalities Information Form**

This section includes questions on age, ethnicity and disability. The information is strictly confidential and will only be used for statistical and monitoring purposes. We will not make it available to third parties in accordance with the Data Protection Act (1988).

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| **Gender:**[ ]  Female[ ]  Male[ ]  Transgender[ ]  Prefer not to say[ ]  Other | **Date:**Click here to enter a date. | **What age group do you fit into?** |
| [ ]  16 -24[ ]  25 - 34[ ]  35 - 49 | [ ]  50 - 64[ ]  65 - 79[ ]  80+ |
| **Pregnancy and maternity – as a woman, are you pregnant, on maternity leave or returning from maternity leave?( gave birth in the last 26 weeks)**Yes [ ]  No [ ]  Prefer not to say [ ]  | **What do you consider your sexual orientation to be?**[ ]  Bisexual[ ]  Gay[ ]  Lesbian[ ]  Transsexual[ ]  Heterosexual[ ]  Prefer not to say[ ]  Other |
| **Are you married, co-habiting or in a civil partnership?** Yes [ ]  No [ ]  Prefer not to say [ ]  Other [ ]   |
| **Do you consider yourself to be deaf or disabled?** Section 6(1) of the Equality Act 2010 states that a person has a disability if: (a) That person has a physical or mental impairment, and (b) The impairment has a substantial and long-term adverse effect on that  person’s ability to carry out normal day-to-day activities.Yes [ ]  No [ ]  Prefer not to say [ ]   |
| **If yes, please tick all that apply?**[ ]  Physical Disability [ ]  Mobility difficulties[ ]  Visual Disability/Difficulty[ ]  Hearing Disability/Difficulty[ ]  Mental Health | [ ]  Learning Disability/Difficulty[ ]  Long-term illness/medical condition [ ]  Progressive medical condition [ ]  Speech difficulty [ ]  Facial disfigurement |
| **What is your ethnic group?***Choose one section from A to F, then the appropriate box to indicate your ethnic group.* |
| **A White**[ ]  British[ ]  Welsh[ ]  English[ ]  Irish[ ]  Scottish[ ]  Any Other White background, please enter details: Click here to enter text.  | **B Mixed**[ ]  White and Black Caribbean[ ]  White and Black African[ ]  White and Asian[ ]  Any Other Mixed background, please enter details: Click here to enter text. |
| **C Asian or Asian British**[ ]  Indian[ ]  Pakistani[ ]  Bangladeshi[ ]  Any Other Asian background, please enter details: Click here to enter text. | **D Black or Black British**[ ]  Caribbean[ ]  African[ ]  Any Other Black background, please enter details: Click here to enter text. |
| **F Romany, Gypsy or Traveller**[ ]  Romany[ ]  Gypsy[ ]  Traveller of Irish Heritage, [ ]  Traveller of European Heritage [ ]  If other, please enter details: Click here to enter text. |
| **E Chinese or other ethnic group**[ ]  Chinese[ ]  Any Other, please enter details: Click here to enter text. |