**North Somerset Wellbeing Service**

**Referral Form**

**What we provide**

This service is for people whose mental health difficulties limit their personal independence and who need support with their personal recovery beyond that otherwise offered through primary care. It aims to reduce people needing to access secondary mental health services as well as providing a pathway for those in need of additional support to manage the transition from secondary services into the community successfully. Before making a referral please consider whether the ‘Positive Step’ service is more appropriate to the person you are referring (https://positivestep.org.uk/).

We support people to create and complete a personal wellbeing plan with access to ‘recovery college’ style learning activities and one-to-one review. People can also self-refer direct to our service if they believe they will benefit from our support.

**Contact us**

If you would like to speak with us before making a referral please contact 0333 023 3504 (Monday-Thursday 9am-4.30pm and Friday 9am-1pm) or email [NSWellbeing@second-step.co.uk](mailto:NSWellbeing@second-step.co.uk).

**Referrer information**

|  |  |
| --- | --- |
| Your Name: |  |
| Profession / role: |  |
| Organisation: |  |
| Phone no: |  |
| Email: |  |

**Person being referred:**

|  |  |  |
| --- | --- | --- |
| Full Name: |  | |
| Address: |  | |
| Phone no: |  | |
| Email: |  | |
| Date of birth: |  | |
| Diagnosis / nature of mental health difficulties: |  | |
| Previous use of mental health services: |  | |
| Is the person you are referring willing to work with in partnership with the service on their recovery and wellbeing? | | **Yes / No** |

**Exclusion criteria:**

(Please note that if the answer to any of the following questions is ‘yes’ this service is unlikely to be appropriate.)

|  |  |
| --- | --- |
| Are they currently acutely unwell? | **Yes / No** |
| Do they pose a current significant risk of harm to themselves which requires secondary referral? | **Yes / No** |
| Do they pose a significant risk to others? | **Yes / No** |
| Is the primary reason for their referral substance or alcohol misuse? | **Yes / No** |
| Is the reason for their referral their needs relating to severe learning disability? | **Yes / No** |

**Reason for referral**

|  |
| --- |
| Please provide any further information relevant to this referral: |

**Please confirm client’s permission for us to make contact**

|  |  |  |  |
| --- | --- | --- | --- |
| The person being referred has consented to their data being shared with us: | | | **Yes / No** |
| The person being referred is happy to be contacted by (tick all that apply): | | | |
| [ ] Landline phone | [ ] Voicemail | [ ] Email | |
| [ ] Mobile phone | [ ] Text | [ ] Letter | |

|  |  |
| --- | --- |
| Signed: | Date: |

Please return this form to [NSWellbeing@second-step.co.uk](mailto:NSWellbeing@second-step.co.uk) or North Somerset Wellbeing Service, 69 Old Street, Clevedon, BS21 6BT.