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| Access Community Mental Health Referral Form |
| ***Practice information*** |
| Date of Referral |  | Practice: |  |
| Name of referrer (and GP if different) : |  | Address: |  |
| ***Patient information*** |
| Consent to text messages | [ ]  Yes [ ]  No | Consent to phone messages | [ ]  Yes [ ]  No |
| First Name |  | Surname  |  |
| Address |  | DOB |  |
| Gender |  |
| Pronouns |  |
| Home Tel Number |  |
| Postcode  |  | Mobile Number |  |
| What would individual like support with? *Please include if they have been given a mental health diagnosis, and whether they agree with this diagnosis* |
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| Any other agencies involved in the individual’s care? *Please provide names of agencies and workers* |
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| Risk information (to self or others) *Please provide details* |
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| ***Confidentiality and data protection*** |
| If you are in Swindon or BANES, your information will be stored by [Second Step](https://www.second-step.co.uk/wp-content/uploads/2024/05/SS_A5_PROTECTINGINFO_LEAFLET_ELEC_MAY2024.pdf). If you are in Wiltshire your information will be stored by [Alabaré.](https://alabare.co.uk/privacy-notice-servuce-users-and-clients/) Please see respective privacy policies. Questions can be sent to DPO@second-step.co.uk or enquiries@alabare.co.uk.Please confirm this referral has been discussed with the client and they have given consent for information to be shared:[ ]  Yes [ ]  No  |