Care in Mind

REFERRAL FORM

CLIENT DETAILS	
SURNAME:	
FORNAME:	
DATE OF BIRTH:	
ADDRESS: **TELEPHONE:**	
ETHNICITY:	
NEXT OF KIN:	**ADDRESS:** **TELEPHONE NUMBER:**
REFERRAL AGENT DETAILS	
SURNAME:	
FORNAME:	
PROFESSION:	
ADDRESS:	
TELEPHONE NUMBER: **E-MAIL:**	

ADDITIONAL INFORMATION
Please give details of any other information that you believe we should be made aware of

CLIENT SERVICES
Support Recovery Programme
Creative Writing
Family Mediation
Healthy Living
Relapse Prevention
Self-confidence and Self-esteem Self-Help Group

Clients must satisfy the following criteria before accessing any of our services. Please indicate that you/your client (s) satisfies each of the criteria by ticking the relevant boxes.

	Criteria	√
1	Previous experience of suffering from a mental health difficulty or generational unemployment	
2	Willing to access services of his/her own free will	
3	Shows a willingness to respect the confidentiality and dignity of all staff/volunteers and service users	

Client Signature:	**Referral agent signature:**
Date:	**Date:**

OFFICE USE ONLY

Initial interview date: _____

Assessment Date: _____

Name:_____