**Referral Form**

*This programme provides specialist support to people with mental health conditions to help them to get or move closer to paid employment. To be eligible for the programme the person must meet the following criteria. Please check that they do prior to submitting this form.*

*I confirm that the person:*

|  |  |
| --- | --- |
|  | is over 18 |
|  | feels that their mental health is a barrier to employment |
|  | lives in Hull  lives in the East Riding  lives in North Yorkshire |
|  | is able to travel independently to The Work Place, The Railway Station, Station Road, Cottingham |
|  | is aware of the referral and the details on this form |

**Referrer Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Your name |  | Job title |  |
| Your organisation |  | Contact Telephone |  |
| Organisation address |  | Contact Email |  |
| Date of referral |  | | |

**Details of the person you are referring**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Contact Telephone |  |
| Address |  | Contact Email |  |
| NI Number (if known) |  | Date of Birth |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Details about the person’s current heath and work situation** *(please tick all that apply)* | | | | |
| **Employment / benefit status** | |  | **Current Mental health support received** | |
| Not in work / not receiving benefits |  |  | Support from Community Mental Health Team (Secondary MH care services) |  |
| Not in work and claiming UC/JSA |  |  |
| Not in work and claiming ESA |  |  | Support from IAPT / East Riding Emotional Wellbeing Service (primary care) |  |
| In full time education |  |  |
| In part time education |  |  | Support from GP only |  |
| Volunteering |  |  | Mental health voluntary organisation |  |
| Parental responsibilities |  |  | Private counsellor / therapist |  |
| Caring responsibilities |  |  | No mental health support |  |
| Working (F/T or P/T) |  |  | Other |  |

|  |
| --- |
| **Please use the space below to tell us what is important *to* them**  (their motivation, what their goals are, who is significant in their life etc.) |
|  |

|  |
| --- |
| **Please use the space below to tell us what is important *for* them**  (what support they may need, communication or access issues) |
|  |

|  |  |  |
| --- | --- | --- |
| **Are there any literacy barriers we need to be aware of?** | ***Yes*** | ***No*** |
| *If yes please give more detail:* | | |

|  |  |  |
| --- | --- | --- |
| **Are you aware of any risks that this person poses to themselves or others?** | ***Yes*** | ***No*** |
| *If yes please give more detail:* | | |

|  |  |  |
| --- | --- | --- |
| **Are there any medical conditions we need to be aware of?** | ***Yes*** | ***No*** |
| *If yes please give more detail:* | | |

Thank you for completing this form. Please return by email to: [hello@workingforhealth.co.uk](mailto:hello@workingforhealth.co.uk) using **password protection**. Or by post to: Working for Health CIC, The Railway Station, Station Road, Cottingham, HU16 4LL

--------------------------------------------------------------------------------------------------OFFICE USE ONLY----------------------------------------------------------------------------------

|  |  |  |
| --- | --- | --- |
| Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Reviewed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Assigned to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Comments: | |
| ATI | Work Place | CG4 Other |

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- |
| Date | Record of discussion | Staff Initial |
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