**Referral Form**

*Please complete all sections of this form. If there is any information missing, we may need to contact you by telephone, and this may delay enrolment and support.*

*Some of our programmes require people to meet certain eligibility criteria. Please check the relevant boxes below so that we can assess which programme you / they may be eligible for.*

*I confirm that I / 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 Selby District |
|[ ]  is able to travel independently to The Work Place, The Station, Station Road, Cottingham HU16 4LL |
|[ ]  is aware of the referral and the details on this form |

**Your details / details of the person you are referring**

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

**Referrer details if different to above**

|  |  |  |  |
| --- | --- | --- | --- |
| Your name |  | Job title  |  |
| Your organisation  |  | Contact Telephone |  |
| Organisation address |  | Contact Email |  |
| Date of referral  |  |
| **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 with limited capability for work & claiming UC/ESA |  |  | Support from Let’s Talk / East Riding Emotional Wellbeing Service (primary care) |  |
| In full time education |  |  | Support from GP only  |
| In part time education |  |  | Mental health voluntary organisation |  |
| Volunteering |  |  | Private counsellor / therapist |  |
| Parental responsibilities |  |  | Employer support e.g. occupational Health |  |
| Caring responsibilities |  |  | No mental health support |  |
| Working (F/T or P/T) |  |  | Other |  |

|  |
| --- |
| **What is currently happening right now?** |
|  |

|  |
| --- |
| **What outcome do you want from this referral?** |
|  |

|  |
| --- |
| **What support is needed from us to achieve this?** |
|  |

|  |  |  |
| --- | --- | --- |
| **Are there any medical conditions or risks that 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 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 | This Ability Other |