

Referral Form



Referral Date	<input type="text"/>	Completed by	<input type="text"/>
Last referral date	<input type="text"/>	Last Discharge Date	<input type="text"/>

PERSON DETAILS

First Name(s)	<input type="text"/>	DOB	<input type="text"/>
Surname	<input type="text"/>	Sex	Male <input type="checkbox"/> Female <input type="checkbox"/>
NHS Number	<input type="text"/>		

ADDRESS/CONTACT DETAILS

Address 1	<input type="text"/>	Telephone	<input type="text"/>
Address 2	<input type="text"/>	Mobile	<input type="text"/>
City/Town	<input type="text"/>		
County	<input type="text"/>		
Post Code	<input type="text"/>		
		Preferred method of contact:	
		Letter <input type="checkbox"/>	Phone call <input type="checkbox"/>

NEXT OF KIN

Name	<input type="text"/>	Telephone	<input type="text"/>
Address	<input type="text"/>		

GENERAL PRACTITIONER

GP Surgery	<input type="text"/>	GP Name	<input type="text"/>
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EQUALITY AND DIVERSITY

Nationality	<input type="text"/>	Language	<input type="text"/>
Ethnicity	<input type="checkbox"/> White British <input type="checkbox"/> White Irish <input type="checkbox"/> White Other <input type="checkbox"/> Mixed - White & Black Caribbean <input type="checkbox"/> Mixed - White and Black African <input type="checkbox"/> Mixed - Other <input type="checkbox"/> Asian/Asian British - Indian <input type="checkbox"/> Asian/Asian British - Pakistani <input type="checkbox"/> Asian/Asian British - Other <input type="checkbox"/> Black/Black British - Caribbean <input type="checkbox"/> Black/Black British - African <input type="checkbox"/> Black/Black British - Other <input type="checkbox"/> Chinese <input type="checkbox"/> Other Ethnicity – Please state: _____		
Sexuality	<input type="text"/>	Religion	<input type="text"/>
Disability	<input type="checkbox"/> No disability <input type="checkbox"/> Mobility and gross motor <input type="checkbox"/> Learning disability <input type="checkbox"/> Sight <input type="checkbox"/> Manual dexterity <input type="checkbox"/> Perception of physical danger <input type="checkbox"/> Speech <input type="checkbox"/> Progressive conditions/physical health <input type="checkbox"/> Personal, self-care and continence <input type="checkbox"/> Hearing <input type="checkbox"/> Behaviour and emotional <input type="checkbox"/> Other		

Information and communication needs Give details of any info/communication needs (e.g. interpreter required, large-print, BSL, induction loop)

REFERRER

Details of the person making this referral if not the person named above.

Name of referrer:	<input type="text"/>	Agency (if professional):	<input type="text"/>
Relationship to client:	<input type="text"/>	Contact Number:	<input type="text"/>

PARIS ID: _____

Drug/alcohol use

Give details of:

- any current/recent/past drug or alcohol use
- any previous drug/ alcohol treatment received

Physical/Mental Health

Give details of:

- physical health issues
- mental health issues
- prescribed medications
- involvement with mental health services

Are you receiving treatment for any physical health problems? If yes what...

Carers

Are you a carer for someone? Is someone a carer for you? Give details.

Family/Carer Involvement

Unity encourage the involvement of family members/carers in your treatment. Who would you like to have involved in your support?

Armed Forces Status

- | | | |
|--|--|--|
| <input type="checkbox"/> Current reservist personnel | <input type="checkbox"/> Current serving personnel | <input type="checkbox"/> Family of personnel |
| <input type="checkbox"/> Ex-reservist personnel | <input type="checkbox"/> Ex-serving personnel | <input type="checkbox"/> Not applicable |

Other relevant info

Give brief details of:

- criminal justice involvement
- housing
- education/employment

Family & Children

Childs Name	D.O.B	Address	GP	Relationship

Referrals can be made in person, over the phone, by post, fax or e-mail:

<u>Office</u>	<u>Address</u>	<u>Telephone</u>	<u>Fax</u>
Carlisle	Unity, 1 st Floor, Stocklund House, Carlisle, CA3 8SY	01228 212060	01228 535681
Workington	Unity, 6 Finkle Street, Workington, CA14 2AY	01900 270010	01900 873136
Whitehaven	Unity, 21b Lowther Street, Whitehaven, CA28 7DG	01946 350020	01946 591391
Barrow	Unity, 92-96 Duke Street, Barrow, LA14 1RD	01229 207020	01229 615659
Kendal	Unity, White Horse Yard, 39 Stricklandgate, Kendal, LA9 4LT	01539 742780	01539 739420

unity@gmmh.nhs.uk

Office use

Form completed by:

Appt Date/Time:

PARIS ID: _____