**Gwent Mental Health Consortium**

**Referral/Contact Form**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| For Referrals please forward completed forms to:  **Gwent Mental Health Consortium**  **Tel:** 01633 810718 **Email:**  [info@growingspace.org.uk](mailto:info@growingspace.org.uk)  By submitting this referral (either as an individual or an agency with the consent of an individual), consent is being given for the storing and sharing of information with partner agencies:   * The sharing of information with Consortium partners * The storage of information in line with data protection regulation. | | | | | |
| **Personal Details** | | | | | |
| Mr  Mrs  Miss  Ms  (tick appropriate) | | | | | |
| Full Name: Click here to enter text. | | | | | |
| Date of Birth: Click here to enter text. | | | | | |
| Address: Click here to enter text. | | | | | |
| Postcode: Click here to enter text. | | | | | |
| Tel:  Click here to enter text. | | Mobile:  Click here to enter text. | | Email:  Click here to enter text. | |
| **Emergency Contact Details** | | | | | |
| Name: Click here to enter text. | | | | | |
| Address Click here to enter text. | | | | | |
| Postcode: Click here to enter text. | | | | | |
| Telephone number: Click here to enter text. | | | | | |
| **GP Details (for counselling referrals)** | | | | | |
| G.P Name: Click here to enter text. | | | | | |
| Surgery address: Click here to enter text. | | | | | |
| Telephone Number: Click here to enter text. | | | | | |
| **Which Local Authority area do you live in? (please indicate)** | | | | | |
| Newport | Torfaen | | Blaenau Gwent | Caerphilly | Monmouthshire |

|  |
| --- |
| Please can you describe your mental health issues and/or caring role. |
| Click here to enter text. |
| Please can you describe the support required in relation to your needs. |
| Click here to enter text. |
| Please detail any existing support you are receiving. |
| Click here to enter text. |
| Your referral will be passed to the Information, Advice and Assistance staff in your area who will contact you to discuss your needs. |

|  |  |
| --- | --- |
| **Referrer** | **Contact Details: (Name Address Telephone)** |
| Health Secondary Services (CMHT) | Click here to enter text. |
| Health Primary Care (PCMHSS) | Click here to enter text. |
| Third Sector Organisation | Click here to enter text. |
| G.P | Click here to enter text. |
| Self-Referral | Click here to enter text. |
| Other Organisation (please state) | Click here to enter text. |

|  |
| --- |
| Are there any risk issues that we need to be aware of? (for example; risks to yourself or to others)  Click here to enter text. |

|  |
| --- |
| Do you have a drug, alcohol or substance misuse problem?  Yes  No  Prefer not to say  If yes please say a little bit more about the problem, such as which substance or drug and how long you have had the problem. Click here to enter text. |

|  |
| --- |
| Any Other Information?  Click here to enter text. |
| **Consent**  By submitting this referral/contact form, consent is being given for the:   * Sharing of information with Consortium partners * The storage of information in line with data protection regulations.     For more information about how we collect, use, protect and store your information please see a full copy of our privacy notice which is available to you and can be accessed via our website:  www.gwentmentalhealthconsortium.org |
| Date of Referral: Click here to enter a date. |

**Equalities Information Form**

This section includes questions on age, ethnicity and disability. The information is strictly confidential and will only be used for statistical and monitoring purposes. We will not make it available to third parties in accordance with the Data Protection Act (1988).

|  |  |  |  |
| --- | --- | --- | --- |
| **Gender:**  Female  Male  Transgender  Prefer not to say  Other | **Date:**  Click here to enter a date. | **What age group do you fit into?** | |
| 16 -24  25 - 34  35 - 49 | 50 - 64  65 - 79  80+ |
| **Pregnancy and maternity – as a woman, are you pregnant, on maternity leave or returning from maternity leave?( gave birth in the last 26 weeks)**  Yes  No  Prefer not to say | | **What do you consider your sexual orientation to be?**  Bisexual  Gay  Lesbian  Transsexual  Heterosexual  Prefer not to say  Other | |
| **Are you married, co-habiting or in a civil partnership?**  Yes  No  Prefer not to say  Other | |
| **Do you consider yourself to be deaf or disabled?** Section 6(1) of the Equality Act 2010 states that a person has a disability if: (a) That person has a physical or mental impairment, and (b) The impairment has a substantial and long-term adverse effect on that  person’s ability to carry out normal day-to-day activities.  Yes  No  Prefer not to say | | | |
| **If yes, please tick all that apply?**  Physical Disability  Mobility difficulties  Visual Disability/Difficulty  Hearing Disability/Difficulty  Mental Health | | Learning Disability/Difficulty  Long-term illness/medical condition  Progressive medical condition  Speech difficulty  Facial disfigurement | |
| **What is your ethnic group?**  *Choose one section from A to F, then the appropriate box to indicate your ethnic group.* | | | |
| **A White**  British  Welsh  English  Irish  Scottish  Any Other White background, please enter details: Click here to enter text. | | **B Mixed**  White and Black Caribbean  White and Black African  White and Asian  Any Other Mixed background, please enter details: Click here to enter text. | |
| **C Asian or Asian British**  Indian  Pakistani  Bangladeshi  Any Other Asian background, please enter details: Click here to enter text. | | **D Black or Black British**  Caribbean  African  Any Other Black background, please enter details: Click here to enter text. | |
| **F Romany, Gypsy or Traveller**  Romany  Gypsy  Traveller of Irish Heritage,  Traveller of European Heritage  If other, please enter details: Click here to enter text. | |
| **E Chinese or other ethnic group**  Chinese  Any Other, please enter details: Click here to enter text. | |