****c

**For URGENT/CRISIS Referrals DO NO USE THIS FORM please call Crisis Single Point of Access on 0800 090 2456**

 Please email form to: **capsa@blackthrive.org**

|  |
| --- |
| **Consent to referral and information sharing with Black Thrive :** [x]  |
| **Date of Referral** |   |

|  |  |
| --- | --- |
|  **PATIENT**  | **REFERRER**  |
| **Name**  |  | **Name**  |  |
| **NHS Number** |  | **Role** |  |
| **DoB****Age** |  | **Organisation** |  |
| **Address**  |  | **Email** |   |
| **Ethnicity** |  | **Phone Number** |  |
| **Gender + Pronouns** |  |  |  |
| **Email address** |  | **GP practice (names of key GPs liaised with, if known)** |  |
| **Phone Number** |  | **GP practice staff contact number(s) and/or email(s) (otherwise general)** |  |
| **Preferred communication method:**  |
| **Interpreter or BSL required** [ ] **Language:**  | **Alternative Correspondence format** |       |
| **Transport/ Accessibility Needs** |  | **Advocacy Needs** |  |
| **Specify if the patient requires any other considerations to be made in order to access services**:  |
| **Does the patient have a carer? If not, are they in the process of sourcing one?**  |
| **Any children/dependents?**  |
| **REASON FOR REFERRAL + EXPECTATIONS**  |
| **What does the patient want to achieve? How would they like to be supported?** **What have been the patient’s challenges to: a) accessing services b) maintaining practical/ social welfare and/or c) realising recovery goals?** **Why is culturally appropriate care important to them? How do they think it would make a difference to their life?** **What are the referrer’s hopes for the patient? Any key areas that you have already identified?**  |
| **HEALTH & WELLBEING SUPPORT** |
| **Mental health conditions (+ diagnoses):** **Physical health conditions (+ diagnoses):** **Any medication taken and effects:** **Relationship with current prescribed medication (and any documented history):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Previous or current contact with mental health services or social services:****Key support staff (+ contact information) identified:** **Would the patient be happy for us to contact support staff where it may benefit the quality of support for their needs? *Please inform them that we will always consult with them for additional verbal consent before ever getting in contact with them*** **Relationship with past and current services:****Any identified protective factors:** **Any identified interests, values and/ or motivators:** **Any other information you think is relevant:** |
| **SAFEGUARDING** |
| **What current and past RISK issues (to self, to others, from others, property, alcohol and substance misuse) should we be aware of? \*Please attach any risk notes** **Any important triggers (e.g. behavioural, environmental, sensory stimuli) to note? How have these been managed in the past?**  |
| **FURTHER SUPPORTING INFORMATION**  |
| **Any other information you think is relevant:** **Copy of relevant consultations (please tick)**:  |

Please email form to: **capsa@blackthrive.org**