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**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**](mailto:capsa@blackthrive.org)

|  |  |
| --- | --- |
| **Consent to referral and information sharing with Black Thrive :** | |
| **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)**: | | | |

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