**Flourish Referral Form**

**Email: Flourish@hertsmindnetwork.org**

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| Date of referral: | | |  | | | | |
| Verbal consent obtained for referral (if being referred by an agency): | | | Yes  No | | | | |
| New/ previous referral: | | | New  Previous | | | | |
| Name of referrer | | |  | | | | |
| Title: | Forename: | | | | | Surname: | |
| Address: | | | | D.O.B: | | | |
| Postcode: | | | | First language:  Second Language if spoken: | | | |
| Telephone number and time to call:  Is it ok to leave a message? Yes  No | | | | Do you require an interpreter? Yes  No | | | |
| Can we text you on your mobile? Yes  No | | | | | | | |
| Email: | | | | | | | |
| Are there any children under 18? Yes  No | | | | Do they live at home? Yes  No | | | |
| Name | | Date of birth | | | Name | | Date of birth |
|  | |  | | |  | |  |
|  | |  | | |  | |  |
| Housing status: (Private rented, mortgage, Housing Association): | |  | | | | | |
| Other agencies involved (e.g. Housing, Refugee Council, Mental Health, etc.): | |  | | | | | |
| Description of areas of mental health need and reason for referral: | | | | | | | |
| Any additional notes: | | | | | | | |

**Disclosure**

*We are required by the Data Protection Act 2003 to have the client’s consent for us to 1) request information from or share information with other services 2) keep a record of their support from Hertfordshire Mind Network. All information will be dealt with as per Hertfordshire Mind Network’s Data protection & Confidentiality Policy.*

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| **I confirm that the client has agreed to this information being passed to Hertfordshire Mind Network. The client understands that information may be passed to other agencies.**  Please check the box to consent to the above ☐ |

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| **Client’s name: Date:**  Referrals are occasionally received which may be deemed appropriate for one or more of our services. Please check this box if the client agrees to this referral being transferred internally if appropriate ☒  (the client and referrer will be informed in this instance). |