Flourish Referral Form

**Email: Flourish@hertsmindnetwork.org**

|  |  |
| --- | --- |
| Date of referral: |  |
| Verbal consent obtained for referral (if being referred by an agency): |  Yes [ ]  No [ ]  |
| New/ previous referral:  | New [ ]  Previous [ ]  |
| Name and contact details of referrer: |  |
| Title:  | Forename:  | Surname:  |
| Address:  | D.O.B:  |
| Postcode: | Ethnicity/Nationality: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 with you? Yes [ ]  No [ ]  |
| Name | Date of birth | Name | Date of birth |
|  |  |  |  |
|  |  |  |  |
| What is your current re-settlement status? |
| 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.*

**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 [ ]

**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)*.[x]