**Hertfordshire Mind Network Referral Form**

Top of Form

Please complete this form if you would like to access our services and we will contact you to discuss next steps. Please provide as much information as possible. Fields marked with an \* are required

**Date of referral**

Date:

**Your details**

Title       Name\*       Surname\*

Main phone\*       Mobile       Email       Date of Birth\*      

Address\*       Town\*       Postcode\*

Please complete this section carefully. Supporting you to access the right services is very important to us but it isn't always easy to make contact, so listing as many contact options as possible will help us to help you more quickly.

**Contact method**

How would you like us to contact you? Home phone  Mobile  Email

Is it OK for us to leave a message? Yes  No

**Emergency Contact Details:**

In the event of an emergency, who would you like us to contact?

Name       Contact number       Relationship to you

**GP details (if known)**

GP Surgery

**Employment information**

Employed

Unemployed

Not working due to illness

Retired

Veteran

Carer

Student

**Further information**

**Which 1:1 service would you like to access? (Please only select one. If you are unsure of which service you would like to access, please call 0203 727 3600 Mon to Fri 9am – 5pm to discuss).**

1:1 Peer Support

Housing Support Service

Community Support Service

Domestic Abuse Service

Hertswise

Carers Support

Flourish

Mums Matter Peer Support (for mums with perinatal mental health needs & children under 2 years old)

**Which groups and activities would you like to access?**

Peer Support Groups  Peer Learning Courses  Music Group

Meeting Places (Online and Face-to-face)  Online LGBTQ Group

Mums Matter (for mums with perinatal mental health needs & children under 2 years old)

To see information about our services, please see [www.hertfordshiremind.org](http://www.hertfordshiremind.org)

**What are your three main concerns that are affecting your wellbeing at the moment?\***

**Is there any additional information we need to know for you to access our services? e.g. language, disability, access issues? \***

**How did you hear about us? \***

GP

Wellbeing Service/ IAPT

Mental Health Team

Adult Care Services

CAMHS

Promotional event

Probation

Previously used HMN

Friend or family

Our website

Social media

Frontline

Other

**Details of referrer (if completing the form on behalf of someone else)**

Name of referrer       Organisation

Email       Tel number

**Equal Opportunities and Disability Monitoring**

**Age Group**

18 or under  18-24  25-34  35-44  45-54  55-64

65-74  75-84  85-89  90+  Prefer not to say

**Gender**

Male  Female  The gender above is not the one given to me at birth

Prefer not to say  Other gender description (please specify)

**Religion/ faith**

No religion/ faith  Christian (any denomination)  Buddhist  Hindu

Sikh  Muslim  Jewish  Other  Prefer not to say

**Sexual orientation**

Bisexual  Gay man  Lesbian/ Gay woman  Heterosexual

Prefer not to say  Other sexual orientation description (please specify)

**Disability**

Disability: Are your day-to-day activities limited because of a health problem or disability which has lasted or expecting to last for at least 12 months?

None  Physical impairment (such as mobility)  Behavioural/emotional

Sensory impairment (such as sight or hearing)  Long-term illness or condition

Learning disability  Mental health condition  Prefer not to say

Other disability description (please specify)

**Ethnicity**

White British

White Irish

Any other White background

Mixed – White and Black Caribbean

Mixed - White and Black African

Mixed - White and Asian

Any other mixed background

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background

Caribbean

African

Any other Black background

Any other ethnic group

Not stated

Prefer not to say

**Relationship status**

Single  Married  Civil partnership  Divorced  Widowed  Prefer not to say

Cohabiting

**Caring responsibilities**

Primary carers of a child (under 18)

Primary carer of disabled child/ children

Primary carer of disabled adult (18 and over)

Primary carer of older person

Secondary carer

None

**Autism**

Autism diagnosis  Awaiting autism assessment

**Data Protection and Confidentiality**

Hertfordshire Mind Network adheres to the Data Protection Act 2018’s principles of good information handling and the EU General Data Protection Regulation 2018.

Please indicate below if you consent to us collecting, recording and processing your personal data for the purpose of providing you with support and to ensure your health, safety and wellbeing. We will use your information appropriately and in line with our Privacy Policy which you can see here: [Privacy Policy](https://www.hertsmindnetwork.org/privacy-policy-new)

Your details will not be shared with anyone else without your consent. If you have any concerns or questions about how your personal data is collected and used, please ring us on 02037 273600 or email us at [info@hertfordshiremind.org](mailto:info@hertfordshiremind.org). Please note that without your consent, you will not be able to submit this form and access Hertfordshire Mind Network’s services.

Where information is given in confidence that Hertfordshire Mind Network believes poses a risk to the client, a risk to other people, a risk to the safety and welfare of a child, or is against the law, we reserve the right to disclose that information to a relevant third party.

**Do you consent to us collecting, recording and processing your personal data for the purpose of providing you with support and to ensure your health, safety and wellbeing? \***

Yes

No  (Please note we need consent to process your referral)

**Where to send your completed form**

Please email your completed form to [teamadmin@hertsmindnetwork.org](mailto:teamadmin@hertsmindnetwork.org). If you have any questions or would like help filling in this form, please call us on **02037 273600**.