**Hackney WellFamily Plus Service**

**Professionals Referral Form**

Hackney WellFamily Plus is **not a** Crisis Service

If patient/client is in crisis please contact City and Hackney Mental Health Crisis line on 0800 073 0006 or the Samaritans on 116 123.

In an emergency please call 999 or attend the nearest A&E department.

Please read WellFamily Plus Service Inclusion and Exclusion Criteria before making a referral.

**Acceptance and Exclusion criteria**

The service is available to:

• Individuals experiencing mild to moderate **emotional and mental health difficulties** 16 years of age and over

• Individuals registered with a **City and Hackney GP**

**Exclusion criteria:**

• Children unaccompanied underage of 15

• People **not** experiencing mental health or emotional problems

• People with acute psychotic disorders

• People who are at risk, who require secondary care input.

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| PROFESSIONALS REFERRAL FORM: \*Patient/Client must be 16yrs of age or over and be registered with a City & Hackney GP to access WellFamily Plus Service |
|  **Name:** |  | **Surname:** |  |
| **GP surgery:** |   | **Age:**  | **Date of Birth:** |  |
| **NHS number:**  |  |
| **Gender:** Male [ ] Female [ ]  Non-Binary [ ]   Other [ ]  Please state: | **Do they identify as trans?**Yes [ ]  No [ ]  Not sure [ ]  Prefer not to say [ ]  |
| **Pronouns:** |  | **Religion / Belief:**  |  |
| **Ethnicity:** |  | **Nationality:** |  | **Preferred Language:** |  |
| **Interpreter Needed:** | **Yes** [ ]  **No** [ ]   |
| **Sexuality:** | Heterosexual (straight)[ ] Bisexual [ ]  Gay or Lesbian [ ]  Not sure [ ] Prefer not to say [ ]  Other [ ]  Please state: |
| **Address:**  |  | **Postcode:** |  |
| **Living situation:** e.g. in hostel, with family, homeless |  |
| **Contact number:** |  | **Email address:**  |  |
| **Is it okay to receive texts / voicemails / emails?**  Yes [ ]  No [ ]  if no, please give further details: |
| **Occupation:** | In education [ ]  In employment [ ]  Not in education or employment [ ] Please state: |
| **Have any children?** Yes **[ ]** No **[ ]** If yes, please give name of child(ren) and date(s) of birth: |
| Are they pregnant?  | Yes **[ ]** No **[ ]**  Please state: |
| Do they have a learning disability? | Yes **[ ]** No **[ ]**  Please state: |
| Do they consider themselves to have any developmental, medical or physical conditions?  | Yes **[ ]** No **[ ]**  Please state:If yes, do they have any access needs? |
| AREAS OF SUPPORT (PLEASE TICK AS MANY THAT APPLY) |
| **Emotional Support:**Low mood [ ]  Anxiety [ ]  Identity [ ]  Relationships [ ]  Trauma [ ]  Substance or alcohol misuse/dependency [ ]  Eating Issues [ ]  Abuse [ ]  Other [ ]  Please State: **Practical Support:**DV [ ]  Housing [ ]  Finances [ ]  Welfare Benefits [ ]  Education and Employment [ ]  Social Activities [ ]  Other [ ]  Please State:  |
| **OVERVIEW OF SUPPORT**  |
| **Why is the patient/client seeking support? Please provide as much information as possible, including any assessments that you may have already completed**  |
|  |
| **OVERVIEW OF RISK**  |
| Please provide any past or present risk associated with patient/client |
| Suicidal ideation [ ]  Previous suicide attempt/s [ ]   | Current self-harm [ ] History of self-harm [ ] Substance/alcohol abuse [ ] [ ]  | Forensic History [ ] Current risk to others [ ] Previous risk to others [ ]  | Domestic violence risks [ ] Safeguarding Risks [ ]  Children [ ]  Adults [ ]  |
| Please detail the history of risk and any other concerns that you may have: *(Including dates, method, attendance at hospital etc.)* |
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| **OTHER SERVICES THAT SUPPORT PATIENT/CLIENT** |
| Is the patient/client currently receiving / have they received support from any of the following services?  | **Currently:** Social Care [ ]  CAMHS [ ]  Adult Mental Health/Secondary Care Service [ ]  Neighbourhoods team [ ]  Specialist Psychotherapy Service [ ]  IAPT / Talk Changes [ ]  Young Hackney [ ]  Private Therapy [ ]  None [ ]  Other [ ]  (if other please detail)………………… | **In the past:**Social Care [ ]  CAMHS [ ]  Adult Mental Health/Secondary Care Service [ ]  Neighbourhoods team [ ]  Specialist Psychotherapy Service [ ]  IAPT / Talk Changes [ ]  Young Hackney [ ]  Private Therapy [ ]  None [ ]  Other [ ]  (if other please detail)………………. |
| If patient/client is involved with other services for their emotional or mental health wellbeing please provide contact details here:  |  |
| Does the patient/client consent to this referral?  |  Yes **[ ]** [ ]  No**[ ]** [ ]  |
| **Referrer Details** |
| **Name of referrer** |  | **Organisation** |  | **Phone number** |  |
| **Role/Job Title** |  | **Email address** |  | **Date** |  |

Please email to hackneywellfamilyplus@family-action.org.uk

**And/or send the referral form to the Hackney WellFamily Plus Senior Practitioner based at the GP Practice patient is registered with.**

Hackney WellFamily Pus Service – Unit 7: The Textile Building, 29a-31a Chatham Place, London E9 6FJ

(entrance on Belsham Street)