**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?** YesNoIf yes, please give name of child(ren) and date(s) of birth: | | | | | | | | | | | | | | | | | |
| Are they pregnant? | | | | | YesNo Please state: | | | | | | | | | | | | |
| Do they have a learning disability? | | | | | YesNo Please state: | | | | | | | | | | | | |
| Do they consider themselves to have any developmental, medical or physical conditions? | | | | | YesNo 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** | | | | | | | | | | | | | | | | | |
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| **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.)* | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **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](mailto: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)