**Hackney WellFamily Plus Service**

**Self Referral Form**

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

If you are worried about your mental health and feel that you are unable to keep yourself safe please call 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 your nearest A&E department.

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| SELF REFERRAL FORM: \*You 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: | | | | | | | | | | | | | |
| **Do you have any children?** YesNoIf yes, please give name of child(ren) and date(s) of birth: | | | | | | | | | | | | | | | | |
| Are you pregnant? | | | | YesNo Please state: | | | | | | | | | | | | |
| Do you have a learning disability? | | | | YesNo Please state: | | | | | | | | | | | | |
| Do you consider yourself to have any developmental, medical or physical conditions? | | | | YesNo Please state:  If yes, do you 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 are you seeking support? Please provide as much information as possible | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **OTHER SERVICES THAT MAY SUPPORT YOU** | | | | | | | | | | | | | | | | |
| Are you currently receiving / have you 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 you are involved with other services for your emotional or mental health wellbeing please provide their contact details here: | | | | |  | | | | | | | | | | | |
| Are you ok with WellFamily Plus contacting services you are involved in? | | | | | Yes  No  Not yet | | | | | | | | | | | |
| Are you or have you been in care or were involved with social services in the past? | | | | | Yes  No  Please state (include name of social worker): | | | | | | | | | | | |
| How did you hear about Hackney WellFamily Service? | | | | |  | | | | | | | | | | | |
| **CONSENT** | | | | | | | | | | | | | | | | |
| **Please sign below**  I consent to Family Action:   * Processing and storing my information given on the form in accordance with The Data Protection Act 2018 and   General Data Protection Regulation 2016/679 (GDPR).   * Processing and storing the personal data I have provided and any supporting information that is required.   If my referral is accepted, Family Action can:   * Seek information from other relevant professionals such as health, social care, education, housing, local authority, police, legal and voluntary services professionals. * Share information with other relevant professionals such as health, social care, education, housing, local authority, police, legal and voluntary services professionals to support my needs.   \*Please note that if you do not consent, we will continue to offer you our support, but the services provided to you may be affected. You can discuss this with your allocated WellFamily Practitioner, and if you have any further queries, with a member of WellFamily Management Team on the details below. | | | | | | | | | | | | | | | | |
| Name: |  | | | | | Signed: | | | |  | | | | | Date: |  |

Please email to [hackneywellfamilyplus@family-action.org.uk](mailto:hackneywellfamilyplus@family-action.org.uk)

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

(entrance on Belsham Street)