Logo

Description automatically generated

**EDAMH Referral Form**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Personal details | | | | | |
| **Name**: | | | | | **DOB**: |
| Address: | | | | | |
| Home tel. number: | | | Mob no: | | |
| First language: | | | Gender: | | |
| Preferred choice of contact:  Telephone  Mail  Email  Txt | | | | | |
| Emergency contact name:  Relationship:  Tel: | | | | | |
| GP name: | | | GP Tel.: | | |
| GP Practice: | | | Email: | | |
| Have you/the client received support from EDAMH before?  Yes  No  If ‘Yes’ which service and when? | | | | | |
| Ethnic origin | | | | | |
| White or White British  Asian or Asian British  Black or Black British  Mixed Background Other Ethnic Group: | | | | | |
| Special requirements | | | | | |
| Physical Disability  Sensory Disability  Language barrier  Autism Disorder  Asperger’s Disorder  Past/current Domestic Abuse  **Please specify any support requirements:** | | | | | |
| Support Network  *Other services involved in your support* | | | | | |
| Name: | | | Tel: | | |
| Name: | | | Tel: | | |
| Name: | | | Tel: | | |
| Referral Details | | | | | |
| Referrer: | | | Relationship to service user: | | |
| Agency: | | | Tel: | | |
| Address: | | | Email: | | |
| Mental health history | | | | | |
| How long have you/the person experienced mental ill health? | | | | | |
| Do you have/the person have a diagnosis?  Yes  No  If ‘Yes’ please specify: | | | | | |
| Have you/the person had previous support from Mental Health Services?  Yes  No  If ‘Yes’ please give the most recent dates and details: | | | | | |
| Are you/the person currently having any suicidal thoughts  Yes  No | | | | | |
| Do you/the person have a plan of how to carry this out?  Yes  No | | | | | |
| Family and relationships | | | | | |
| Single  Married  Partnership  Separated  Divorced  Widow/er | | | | | |
| Please give details of personal support network | | | | | |
| Children |  | | | | |
| Mother |  | | | | |
| Father |  | | | | |
| Brother/s |  | | | | |
| Sister/s |  | | | | |
| Friend/s |  | | | | |
| Living Arrangements | | | | | |
| Living with partner | | | Living alone | | |
| Living with parents/family | | | Living in homeless unit | | |
| Living with friends | | | Living in supported accommodation | | |
| Living with pets:  Yes  No If Yes please specify: | | | | | |
| Employment and Benefits | | | | | |
| **Status** | | **Please give details** | | | |
| Employed | |  | | | |
| Unemployed | |  | | | |
| Student | |  | | | |
| Receiving Benefits | |  | | | |
| Financial issues | |  | | | |
| Risk Assessment | | | | | |
| Are there any areas of risk or concern that EDAMH need to be aware of?  Yes  No  If ‘Yes’ please give details: | | | | | |
| Presenting Issues | | | | | |
| What are the current presenting Mental Health issues? | | | | | |
| What support would assist your recovery/ this person’s recovery? | | | | | |
| Are there any cultural requirements/issues that we need to be aware of?  Yes  No  If ‘Yes’ please give details: | | | | | |
| Any days or times that you are/ the person is unavailable? | | | | | |
| *EDAMH is a Third Sector Organisation and service provider which supports individuals on the grounds of their informed consent and agreement. The information you provide will be held in accordance with the Data Protection Act and EDAMH Privacy Policy. Is the person referred, aware of and in agreement of this referral and the information regarding to them?*  Yes  No | | | | | |
| **Signed:** | | | | **Date:** | |

**Please return the completed form to:**

East Dunbartonshire Association for Mental Health

Suite 7 Enterprise House, Strathkelvin Place, Kirkintilloch, G66 1XQ.

Or email to [referrals@edamh.org.uk](mailto:referrals@edamh.org.uk)

If you have any queries, please call us on 0141 955 3040