REFERRAL FORM

Mental Health Support Service

Individuals Contact Details	
Title:	**Full Name:**
DOB:	**Gender:**
How did you hear of Maan Somali Mental Health Sheffield?	
Address:	**Landline number:** **Mobile number** **Email:**
Contact details for next of kin / carer	**Address:** **Post code:** **Telephone:**
Is it Ok to leave an answerphone message? Y/ N	**Preferred method of contact:**
No of dependent children:	**No of children under 5 years:**
Do you have a Carer? ☐ Yes ☐ No	**Do you have Carer responsibilities?** ☐ Yes ☐ No
Reason For Referral	

Are you on; Probation, licence or have you ever been subject to conditions under MAPPA? Yes / No		
GP details	**Social Worker details**	**CPN /Health Visitor details**
GP Name: **Surgery:** **Location:** **Contact Number:**	**Social Worker Name:** **Contact Number:**	**Health Visitor Name:** **Contact Number:**

Preferred service:	**Preferred Location:**

Self-Referral ☐

Completed by the individual ☐

Completed by Maan SMHS staff ☐
Staff name (if taken over the phone):

Professional referral ☐

Name:	Relationship:
Organisation:	Contact Number/email:

Is the individual aware of this referral?
Yes ☐ No ☐

Support From Other Services

Please indicate whether there is currently any involvement with other agencies that are providing specific support e.g. CPN, IAPT, Social Services etc. ☐ Yes ☐ No ☐ Not sure

Name: **Role:** **Contact details:**
Name: **Role:** **Contact details:**

Is there currently any involvement with a mental health professional from the NHS (psychiatrist, Care Coordinator, Support Worker etc.)? ☐ Yes ☐ No ☐ Not sure

If you answered yes to this question, please give details and include a copy of the most recent Care Plan with the referral

Name: **Role:** **Contact details:**

Which (if any) Maan SMHS services have you accessed in the past?	**Which (if any) other relevant services have you accessed in the past? E.g. IAPT**

Date:		**Name:**		**Signature:**	

For Office Use Only			
Referral Actions: Waiting list letter sent ☐ On database ☐			**Date Actioned:**
			Staff Member:
Date	**Type of contact**		**Outcome**
	Telephone ☐ **Letter/ email** ☐		**Deadline for contact**
	Telephone ☐ **Letter/ email** ☐		**Date referral closed:**
Is service appropriate for individual	Yes ☐	No ☐	
Does this person require signposting to more relevant services/ support? If you answered yes to this question, please confirm details	Yes ☐	No ☐	

Completed by PRINT NAME		**Date**	
Signature of client		**Date**	
Signature of referring agent		**Date**	

Signature of client _____

Signature of referring agent _____

Date _____

We will contact the referring organisation/Individual within 14 days to respond to this referral.

PLEASE ENSURE YOU ALSO COMPLETE/PROVIDE A RISK ASSESSMENT FOR THE REFERRAL.

Please return the completed application to us at via the email address below:

Email: admin.maan@tiscali.co.uk