

Referral

*Thank you for contacting Northamptonshire Mind – your information is important to us and we will treat your application for services with sensitivity and care.  Your personal details will be processed and stored in accordance with the Data protection Act (1988) and the General Data Protection Regulator (GDPR) and in line with Northamptonshire Mind Data Protection Policy.*

Please complete this form as fully as you can, including anything you feel we should know about your current mental health.

**Name (Full)\*:**

**Gender *(please tick):***

**DOB (dd/mm/yyyy)\*:**

**Telephone\*:**

**Male**

**Female**

**Transgender Man**

**Transgender Woman**

**Non-Binary**

**Other *(please state):* \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Prefer not to say**

**Alternate Tel:**

**Email\*:**

**House no/name\*:**

**Flat Building:**

**Street:**

**Town:**

**County:**

**Postcode:**

**Emergency contact\***

**Name:**

**Relationship:**

**Tel:**

**Do you consider yourself to have any disabilities that would require any assistance or adaptations for access into the service locations? Y/N**

**If Yes Please provide details:**

**:**

**Would you consider English to be your preferred language? Y/N**

If NO, please provide details so that we can best support your needs.

**Please give us a brief summary of your present emotional/mental health concerns:**

**Please tick your local Northamptonshire Mind branch where you would like to access services**

**West Northamptonshire: Northampton** [ ]  **Daventry** [ ]  **Towcester** [ ]  **Brackley** [ ]

**North Northamptonshire: Corby** [ ]  **Rushden** [ ]  **Wellingborough** [ ]

**Which areas do you feel you need support from right now? (Please tick all that apply)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Counselling** |  | **Peer Support Groups** |  | **1-1 & Emotional Support** |  | **Crisis Cafe** |  |
| **BBO Support into Employment, Training & Education** |  | **Fresh Minds 18-25’s Peer Support Group** |  | **Wellbeing Education Courses. i.e. Anxiety, Depression, Anger, Life transitions etc.** |  | **Volunteering** |  |
| **SHAPE: Self Harm & Suicide Prevention****Young Persons Service 11-16 yrs.** |  | **Hospital @ Home – Support for individuals discharged from hospital** |  | **Breathing Space – Orbit****Support for tenants of Orbit Housing Association** |  | **Mental Health Navigators** |  |
| **Get Set To Go –****Mental Health & Physical Activity** |  | **Other** |  |  |  |  |  |

*Once we receive your referral we will contact you within 7 days to arrange an appointment to complete an assessment.*

*The assessment process will take approximately 40mins -1hour to complete with one of our mental health support workers. Once the assessment has been completed you will be allocated to the appropriate services. Please be aware that due to increased demand, some of our services do have a waiting list. You will be informed of this during the assessment process.*

**Date:**

**Self-referral Signature:**

**Professional Referral:**

**Name:**

**Organisation:**

**Telephone:**

**Email:**

**Signature: Date:**

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