**Referral Method:** Tel  / Visit to WEB  **/** Post  / Email

**Service Required**: Maintenance for the Mind Confidence building  1:1 Counselling  Listening Service  Caring Dads Trauma and Bereavement Who’s In Charge

Name of Man Referred:

Date referred:D.O.B

Address/Post Code:

Home Phone Number:Mobile Number:

Can message be left on home phone? Yes/No. Can message be left on mobile/by text? Yes/No

Can we write to you at your home address? Yes/No

GP Name & Address:

Emergency Contact Name: Tel No.:

**I agree to this referral being made on my behalf: (Verbal consent can be given if over phone)**

**Name: Signature:**

Please give a short summary of the reason for referral:

Is support needed for any of the following issues? Please tick all that apply:

Isolation  Physical Health  Domestic Violence  Parenting

Mental health  Depression  Stress  Confidence  Relationship Breakdown  Sexual Assault/Abuse  Carer  Other

Willing to attend group induction (please note this may reduce appointment waiting time)

Referred By: Agency:

Contact Details: Signature:

**Referrers, please complete the below in relation to whether the client is a risk to themselves or others. If you select medium or high – please advise why.**

Risk Assessment: Low  Medium  High

Risk Management:

Please take a moment to complete the following form with the client. This information is **vital** to existing and future funding and **ensures our ability to provide these services.**

**Date of Birth **

**Preferred Gender:** MaleFemaleNon-binary **Prefer not to say**

**Ethnic Origin**

**White Asian Black Other Ethnic Group**

British  British  British  Arab

Irish  Indian  African  Mixed Background Other  Pakistani  Caribbean  Other

Gypsy/Irish  Bangladeshi  Prefer not to say

Traveller

Other  Chinese

**Religion or Belief**

No religion  Christian  Buddhist  Hindu  Jewish

Muslim  Sikh  Other Religion  Prefer not to say

**Sexual Orientation**

Heterosexual  Lesbian  Gay  Bisexual  Prefer not to say

**Crime**

Victim of a crime  Offending background

**Disability Caring Responsibilities**

Does you have any physical disabilities? Do you have any caring responsibilities?

Yes: No:Yes: No:

Do you have any learning difficulties? Do you suffer from any visual impairment?

Yes: No: Yes: No:

If you have answered yes to any of the questions, do you require any support? Please specify.