**You are creating a Referral Form for Second Step’s Bristol Sanctuary Service. Under data protection legislation there is a requirement that the person whose details are completed in this form are informed that details of their support will be recorded and shared with Second Step, the client’s GP Practice and Avon and Wiltshire Mental Health Partnership Trust (AWP).**

**We will attempt to make contact on 2 attempts the same day the Referral is received, if we are unable to make contact, we will send an email to you as the referrer. We will not respond to the referrer if we are able to make contact.**

**The client has been informed their details will be shared with Second Step, the client’s GP practice and AWP.**

**Referrer name:** Click or tap here to enter text. **Email:** Click or tap here to enter text.

**Contact number:** Click or tap here to enter text. **Organization:** Click or tap here to enter text.

**Client Name:** Click or tap here to enter text.

**Date of Birth:** Click or tap to enter a date.

**NHS Number:** Click or tap here to enter text.

**Gender:**  Male  Female  Prefer not to say  Prefer to self-describe as Click or tap here to enter text.

**Address:** Click or tap here to enter text.

**Post Code:** Click or tap here to enter text.

**Contact Number:** Click or tap here to enter text.

**Contact Email:** Click or tap here to enter text.

**What are your preferred ways of communicating with the service:** Phone  Email

**Is it safe/appropriate to leave a message?**  Phone  Email  Not appropriate

**GP Details:** Click or tap here to enter text.

**Are you aware if they are currently accessing Mental Health Services?** Yes  No  Unsure

**If Yes, do you have the details:** Click or tap here to enter text.

**Communication and Accessibility needs and preferences:**

Are there any specific Communication or Mobility needs that require support?

|  |  |  |  |
| --- | --- | --- | --- |
| Non-English speaking |  | Wheelchair user |  |
| Visual impairment |  | Seizures |  |
| Blind |  | Mobility issues |  |
| Hard of hearing |  | Learning disability |  |
| Deaf |  | Neurodiversity |  |
| Other, provide information below |  |  |  |

Do you require information to be in a certain Format:

|  |  |
| --- | --- |
| Large Font, if so what Font? |  |
| Easy Read |  |
| Colour Paper, if so what colour ? |  |
| Braille |  |
| Audio |  |
| Other, provide information below |  |
|  |  |

**Presenting difficulties:**

**Please tick any that may apply:**

|  |  |  |  |
| --- | --- | --- | --- |
| Suicidal ideation |  | Emotional intensity |  |
| Self-harm |  | Addiction |  |
| Anxiety |  | Domestic violence |  |
| Depression |  | Physical health ailments |  |
| PTSD (post-traumatic stress disorder) |  | Self-neglect |  |
| OCD (obsessive compulsive disorder) |  | Eating disorder |  |

**Consent to share information**

If there anyone you would like us to share information about your support with, for example a relative, a professional or another agency, a friend or advocate, please give their details below:

|  |  |  |
| --- | --- | --- |
| **Name and address:** | **Relationship to you:** | **Information you would like us to share:** |
|  |  |  |
|  |  |  |

Do any of these people have communication needs?  Yes / No

If yes, what do we need to do to meet them?

|  |
| --- |
|  |

**Details of current mental health difficulties:**

Click or tap here to enter text.

**Risk / Safeguarding concerns if known:**

Click or tap here to enter text.

**Urgency of first contact:**NB Contact times are suggested, please contact Emergency Services or AWP’s Primary Care Liaison Service (North Somerset - 01934 836406 or Sough Glos 0117 3787960 ) for urgent support.

We aim to make first contact within 24 hours unless stated otherwise. The boxes below are to be ticked according to the level of risk for the client

**Same day:**

Same Day: if any suicidal intent or planning is expressed.

**We ask that you ensure all elevated risk clients have contact details for their local intensive support services.**