New	☐

Re-Referral	☐

Close	☐

Client ID	

Referral Form

Staff only section

Wellbeing Coordinator:			
Referral date:		**Date initial assessment is offered:**	

Section One: Your Details			
Name:			
Contact address:		**Postcode:**	
Contact number(s)			
Email:			
Date of birth:		**NHS number:**	
GP Practice:			
Preferred contact:	Letter ☐ Phone ☐ Email ☐ Text ☐		
Preferred language if not English:			

Section Two: Reason for referral			
Primary reason (select one that applies)		**Secondary reasons** (select as many that apply)	
Feeling lonely or isolated	☐	Feeling lonely or isolated	☐

Feeling stressed or anxious	☐	Feeling stressed or anxious	☐
Need advice on health, housing or finance issues	☐	Need advice on health, housing or finance issues	☐
Need emotional support	☐	Need emotional support	☐
Want to find out about local groups and activities	☐	Want to find out about local groups and activities	☐

Details of any other agencies or professionals involved in your support and care within the past 6 months		
Organisation	**Worker**	**Contact Number**
Do you have any specific physical support requirements that would prevent you from seeing us at your GP practice?		YES ☐ NO ☐
Please give details:		

Section Three: Risk					
Who is assessing the risk? Please state:					
Person above's perception of risk (please rate the following)					
Risk	**None**	**Low**	**Medium**	**High**	**Not known**
Self-injury	☐	☐	☐	☐	☐
To public	☐	☐	☐	☐	☐
To staff in workplace	☐	☐	☐	☐	☐
To staff during home visit	☐	☐	☐	☐	☐
To property	☐	☐	☐	☐	☐
Isolation	☐	☐	☐	☐	☐
Self-neglect	☐	☐	☐	☐	☐
Relapse	☐	☐	☐	☐	☐

Offending	☐	☐	☐	☐	☐
Domestic abuse	☐	☐	☐	☐	☐
Other – please state:					
Please give further detail for any areas scoring medium or high (including criminal convictions)					

Please select <u>one</u> of the statements below that applies.

I confirm that verbal consent has been given to me to make a referral on this person's behalf. They're aware that the information given on this form and in any future contact with Connect Well will be used to provide them with support and will be kept confidential. The information given may also be used for monitoring purposes within the Connect Well service and its partners.

Name _____

Position _____

Signature _____

OR

I give consent to Connect Well and its employees to contact me. I understand that the information I give on this form and in any future contact with Connect Well will be kept confidential. I understand that the information given may also be used for monitoring purposes within the Connect Well service and its partners.

Name _____

Signature _____

Please return this form to commlinks.connectwell@nhs.net or

Connect Well, The Reginald Centre, Leeds, LS7 3EX