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| YHST Logo Black And White | **MENTAL HEALTH**  **RECOVERY TEAM****REFERRAL FORM** |  **30 Clarence Street, York, YO31 7EW**Telephone: (01904) 553850MHRSenquiries.30ClarenceSt@york.gov.uk |
|  |  |  |
| Referrers Name:Telephone Number:-Email:-Mobile Number:- | Date of referral | Admission date |
| NHS Number | P Number | Mosaic Number | CPA [ ]  Non-CPA [ ]  |
| Forenames(s) | Surname | AKA | Title |
| HOME ADDRESS: | DOB: AGE: M/F |
|  | SIG OTHER: |
|  | RELATIONSHIP: |
|  | RELIGION: |
| POSTCODE: | TEL:  | ETHNICITY:  |
| CURRENT ADDRESS: | LANGUAGE SPOKEN:  |
|  | EMPLOYMENT:  |
|  | CHILDREN/DEPENDENTS |
|  |
| POSTCODE: | TEL: |
| NEXT OF KIN:  |  |
| RELATIONSHIP:  | CONSULTANT:  |
| ADDRESS:  | GP:  |
|  | SURGERY: |
|   |  |
| POSTCODE: | TEL:  | POSTCODE: | TEL:  |
| CPA CARE COORDINATOR | AGENCY | TELEPHONE |
|   |   |  |
| OTHER PROFESSIONALS INVOLVED IN CARE |
|  |
| NAMED NURSE: | WARD: TEL: |
| OCCUPATIONAL THERAPIST: | WARD: TEL: |
| Reason for referral |
|  |
| Clients perspective about the referral (this can be completed by the client) |
|  |
| Details of Admission |
|  |
| Brief past psychiatric history (Please enclose recent discharge summary or MHA report if possible) |
|  |
| Risk Issues: **(1) Up to date SAMP required for referral to be proc** **(2) No SAMP attach an alternative up to date risk assessment** |
|  Managing mental health ( What are the current mental health issues, how does the person manage them) |
|  |
| Use of alcohol or drugs |
|  |
| Employment/work experience |
|  |
| Physical health |
|  |
| Current problem list |
|  |
| Signature of referrer |
| For Official Use OnlyDate Received:-Receiving Officer:- |
| **Service referred to**  **Training Scheme Cafe or Reception Easy Budget Meals**  **Advice & Guidance Community Groups****Baking Groups** **Well Being groups**  |
| Notes: |