MENTAL HEALTH RECOVERY TEAM

REFERRAL FORM

30 Clarence Street, York, YO31 7EW
Telephone: (01904) 553850
MHRSenquiries.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

Return completed forms to: **Mental Health Recovery Service, 30 Clarence Street, York, YO31 7EW**

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 Only Date Received:- Receiving Officer:-
Service referred to ☐ **Training Scheme Cafe or Reception** ☐ **Easy Budget Meals** ☐ **Advice & Guidance** ☐ **Community Groups** ☐ **Well Being groups** ☐ **Baking Groups**
Notes:

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