**Blue Light Referral Form – Section One** (Please print or use block capitals)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Referral to:**  (Please tick service you wish to refer in to) | Blue Light – Emergency Services support |  |  |  |
|  |  |  |  |

Please return this form to bluelight@heymind.org.uk

|  |  |  |
| --- | --- | --- |
| How did you hear about us? | | |
| Contact name: | Contact number: | Email address: |
| Date Referred: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Client**  **Information** | Title: | First Name: | | Surname: |
| Telephone number: | | | Postal Address: | |
| Alternative telephone number: | | |
| Email address: | | | Postcode: | |
| Registered GP: | | | Date of Birth: | |
| Next of kin name/relationship | | | Next of kin telephone number: | |
| Which Blue Light service do you work for? | | | | |
| Is your employer aware that you are struggling? | | | | |

|  |
| --- |
| Please give details of how you are struggling with your emotional well-being? (E.g. Stress, anxiety, relationship issues, trauma) |

|  |
| --- |
| Please give details of any of your physical health issues (eg mobility problems): |
| Do you have any alcohol or drug related problems? *(please specify)* |
| Are you accessing or currently being supported by any other agencies eg GP, CMHT, Employment Support Agency? |
| As an equal opportunities organisation we would like to ensure that we meet your needs; do you have any specific requirements which would assist us to do this? |
| How would you like us to help the you: |
|  |
| Addition information: |

|  |  |
| --- | --- |
| GP Address: |  |
| Details of any current medication: | |

|  |  |  |
| --- | --- | --- |
| Do you harm yourself or have you done so in the past? | Yes | No |
| Have you harmed or caused injury to others? | Yes | No |
| Do you have thoughts of harming yourself or others? | Yes | No |
| Do you have any anger management issues? | Yes | No |
| Have you experience a specific trauma that you think may be having an impact on your well-being? | Yes | No |
| If you have answered yes to any of the above please give details: | | |

|  |  |  |  |
| --- | --- | --- | --- |
| How would you like us to contact you? | | | |
| Phone | Email | Post | Other (please state) |

**Please return your completed referral form to the email address above.**

For office use only

|  |  |
| --- | --- |
| Date Acknowledged: | Initial Contact: |