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

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| **Referral to:**(Please tick service you wish to refer in to) | Blue Light – Emergency Services support  [ ]  |  |  |  |
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Please return this form to bluelight@heymind.org.uk

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

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| **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?  |

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

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| 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: |
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| Addition information: |

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

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| 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: |

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| 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

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| Date Acknowledged: | Initial Contact: |