**REFERRAL FORM - CONNECT**

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| --- |
| NAME OF CLIENT/PARTNER |
| DATE OF BIRTH  |
| ADDRESSCAN WE SEND LETTERS Y |
| CONTACT TELEPHONE NOCAN WE LEAVE VOICEMAIL MESSAGES? YCAN WE SEND TEXT MESSAGES? Y |
| EMAIL CAN WE EMAIL Y/N |
| PLEASE INDICATE IF CLIENT HAS ANY SPECIFIC COMMUNICATION SUPPORT NEEDS E.G. TRANSLATION SERVICE, BSL, MAKATON ETC |
| MENTAL HEALTH CONDITION/SYMPTOMS |
| KNOWN TO MH SERVICES (name/details of contact if known) Y/N |
| **ISSUES please give details**  |
| HOUSING N |
| DEBT Y |
| UTILITIES N |
| BENEFITS N  |
| OTHER ISSUES N |
| ADDITIONAL INFORMATION  |
| **REFERRER DETAILS** |
| NAME  | ORGANISATION name and address |
| TELEPHONE NUMBER | EMAIL  |
| Please return completed form to Carlisle Eden Mind via email to connect@cemind.org or at 27 Spencer Street, Carlisle CA1 1BE If you wish to discuss completion of referral form please contact Connect on 01228 370633. |