**REFERRAL FORM - CONNECT**

|  |  |
| --- | --- |
| NAME OF CLIENT/PARTNER | |
| DATE OF BIRTH | |
| ADDRESS  CAN WE SEND LETTERS Y | |
| CONTACT TELEPHONE NO  CAN WE LEAVE VOICEMAIL MESSAGES? Y  CAN 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](mailto: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. | |