**Redbridge Social Prescribing Referral Form**

**Please return completed form to:** [**socialprescribing@redbridgecvs.net**](mailto:socialprescribing@redbridgecvs.net)

|  |  |
| --- | --- |
| **Consent** | Information given on this form will be used for the purposes of you getting the support needed. By completing this form you agree that we can use this information on your behalf. It will be held on a computer system run by RedbridgeCVS in accordance with the Data Protection Act. It will be shared on a need to know basis with other partners involved in providing you with support services. Please ask for more information if you are at all unclear. RedbridgeCVS will also contact you for monitoring purposes. Where required, we may get in contact you’re your GP for more details to support your intervention. Please tick this box to give consent. |

**Any queries please get in touch on 020 3874 4132**

**PLEASE NOTE THAT THIS SERVICE IS NOT SUITABLE FOR PATIENTS PRESENTING WITH SEVERE MENTAL HEALTH ILLNESS**

**SELF REFERRAL**

|  |  |  |
| --- | --- | --- |
| **REFERRAL DETAILS**  (Please note this service is for over 18) | | |
| **CLIENTS NAME:** | | **REFERRAL DATE:** |
| Address: | | Date of birth: |
|  | | Postcode |
| Contact Details: Landline number | Mobile number | Gender:  Male  Female  Transgender |
| **Email:** | NHS Number: | Ethnicity: |
| **Patient’s preferred mode of contact(please tick as appropriate):**  **1) Landline : 2) Mobile : 3) Email** | | If you are making this referral on behalf of someone else, please provide your name and contact number: |
| **GP Details:** | | Language or communication needs:  Yes  No  *(if yes, please give details)* |
| **REASON FOR REFERRAL:** *(include all relevant information including other agencies involved and state any health and safety risk)*  Social Isolation – *Do you feel lonely? Do you want to be reconnected to the community.*  Low Mood or stress– *Do you feel low in mood, can prevention and early intervention help you? Is this made worse by your social circumstances?*  Type 2 Diabetes – *Do you need support around health and wellbeing? Do you need support with management of your diabetes?*  Carer – *are you a paid or unpaid* *adult who looks after a family member, partner or friend who needs help and support due to a physical or mental condition and cannot cope without their support*  Other – *have we missed anything you may need to be supported with? Please tell us more.* | | |
| **Additional needs**  ***Please put all additional information regarding reason for self-referral here INCLUDING LONG TERM CONDITIONS.***  ***Please tell us of any additional support needs such as mental or physical disability etc.*** | | |
| **EXTRA IDENTIFIED NEED(S):**  Weight management  Increase exercise  Healthy eating  Addiction (smoking, alcohol, drugs, other)  Learning/Training/Unemployment  Money/Debt/Benefits  Housing Issues  Other (please specify under Reason for Referral)  **The Form can also be posted to : Redbridge CVS Social Prescribing Service, 103 Cranbrook Road, Ilford,**  **IG1 4PU** | | |

