# **South Denbighshire Community Partnership**

# **‘ICAN- Community Wellbeing & Mental Health’**

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| **Referral / Enquiry Form** |

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| 1. **What service support are you seeking to access?** | | | | | | | | | | | |
| Anxiety / Depression | | |  | | Social group activity | | | | | |  |
| Activities/Groups to help improve Mild to Moderate Mental Health | | |  | | Food Bank service | | | | | |  |
| Community Transport Service | | |  | | Advisory Services (Citizens Advice) | | | | | |  |
|  | | |  | | Physical activity groups | | | | | |  |
| Other: | | | | | | | | | | | |
|  | | | | | | | | **Yes** | | **No** | |
| Is the individual over the age of 18 | | | | | | | |  | |  | |
| Is the individual currently under the care of a primary or secondary mental health team? (If Known) | | | | | | | |  | |  | |
| Is the individual happy to work with SDCP and partner organisation KIM Inspire? | | | | | | | |  | |  | |
| Is the individual motivated to working towards goals? | | | | | | | |  | |  | |
| Does the individual have any mobility issues? | | | | | | | |  | |  | |
|  | | | | | | | |  | |  | |
| 1. **Details of Person Being Referred** | | | | | | | | | | | |
| Forename(s): |  | | | | | Surname: | |  | | | |
| Address: |  | | | | | DOB: | |  | | | |
| Tel: | |  | | | |
| Mobile: | |  | | | |
| Email Address: |  | | | | | | | | | | |
|  | | | | | | | |  | |  | |
| 1. **Reason for Referral** | | | | | | | | | | | |
| *Please enter a brief reason as to why you are referring this individual to our services, along with any relevant information (continue a separate sheet if necessary).*  **\*Referrals of too high acuity for ICAN WILL be returned to the referrer\***   |  |  | | --- | --- | | Loneliness/ Isolation |  | | Financial concerns |  | | Mild Mental Health support needs, please explain further (tier 0/1 (low level) early intervention) |  | | Support to Access Social opportunities/ Groups. Please give brief details of interests etc. |  | | Mild Mental Health support needs, please explain further (tier 0/1 (low level) early intervention) |  | | Support to Access Community Transport |  | | Please Provide some background information about the individual | | | | | | | | | | | | | |
| 1. **Risk Assessment** | | | | | | | | | | | |
| *Please provide detail of any risks of which we should be aware (include mental and physical).* | | | | | | | | | | | |
|  | | | | | | | |  | |  | |
| 1. **GP Details of Person Being Referred – If Known** | | | | | | | | | | | |
| GP Name: |  | | | | | Tel: | |  | | | |
| Surgery: |  | | | | | | | | | | |
| 1. **Communication Methods** | | | | | | | | | | | |
| 1. *Please confirm which methods of communication the person being referred has agreed that we can use to contact them (tick all that apply).* | | | | | | | | | | | |
| Phone | | Letter | | Email | | | Text | | Voicemail | | |
| Preferred language: |  | | | | | | | | | | |
|  | | | | | | | |  | |  | |
| 1. **Referrer’s Details** | | | | | | | | | | | |
| Name: |  | | | | | Role: | |  | | | |
| Team: |  | | | | | Tel: | |  | | | |
| Email Address: |  | | | | | | | | | | |
| *By making this referral I confirm that the information on this form is correct, and that consent has been given from the person being referred to share these details with staff at South Denbighshire Community Partnership.*  *Following the submission of this referral form, SDCP will arrange for a phone call by one of their staff or if the referral is Mental Health specific then this will be referred to KIM Inspire to make a Phone call ‘Initial Meeting’ with the referral to determine an agreed course of action. The Referrer will be kept informed accordingly.* | | | | | | | | | | | |

**Please email this form to enquiries@sdcp.org**