Please select the relevant service you wish to make a referral to:

|  |  |
| --- | --- |
|  | Multicultural Mental Health & Wellbeing Service |

|  |  |
| --- | --- |
|  | Advocacy Service |

What is the purpose of this form? (PLEASE READ)

There are three parts to this form:

*Part A – Referral Form:* Allows MSH to provide an initial assessment to see if you are eligible to access their services. The form can be completed by you, with a member of the MSH team or by a referring agency.

*Part B – Service Assessment Form:* If MSH consider you eligible to access one of their services following the initial assessment, a more in-depth assessment of your support needs will be conducted.

*Part C – Service File Information:* Once a full assessment of your service needs has been conducted, you will be allocated a MSH Keyworker and a personal file relating to the service(s) you are accessing will be created so that we can keep a record of all activity relating to your support needs in one place.

PART A Referral Form

The information collected in this form is to help us, help you. All information will be kept private and confidential and is underpinned by our Privacy Policy and in accordance with the Principles of the General Data Protection Regulation (GDPR), and Data Protection Act 2018. All information detailed in this form, along with information we receive about you will be available to you on request. We require your explicit consent to collect sensitive personal information about you which includes your race, ethnic origin, religion, and health (*see the* [*ICO*](https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/special-category-data/) *for more information*). Under the [Principles of the GDPR](https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/principles/) you have the right withhold consent for processing your personal information, however you should be aware that this may impact on the level of service we are able to provide - if you would like to have a chat about this further please speak to a member of the MSH team. For monitoring and evaluation purposes we are required to share your personal information with our funders, which includes Liverpool City Council, in order to report on the impact our services are having on our clients and wider BME community in Liverpool.

Personal Details

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Full Name: |  | | | | | | | | Gender: | |  |
| Address: |  | | | | | | | | | | |
| Postcode: |  | | D.O.B: | | |  | | | | Age: |  |
| Contact No.: |  | | | | | |  | | | | |
| Email: |  | | | | | | | | | | |
| Ethnicity: |  | | | | Religion: | | |  | | | |
| **Language(s):** | |  | | | | | | **Do you require an interpreter?** | | | **Yes  No** |
| **Currently in Paid or Voluntary Work?** | | **Yes  No** | | **National Insurance Number:** | | | |  | | | |

**Next of Kin**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Full Name:** | |  | | **Relationship:** |  | |
| **Address:** |  | | | | **Postcode:** |  |
| **Telephone number:** | | |  | | | |

**GP / Family Doctor**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **DR/GP Name:** | |  | | **Surgery:** |  | |
| **Address:** |  | | | | **Postcode:** |  |
| **Telephone number:** | | |  | | | |

**Housing Information**

|  |  |
| --- | --- |
| **Association/Landlord:** |  |
| **Telephone number:** |  |

**Other Services**

|  |
| --- |
| **Are you involved in any other services? (Psychiatrist, social services etc.)** |

Yes  No  if ‘yes’ please detail below:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service:** |  | | | **Contact Name:** |  | |
| **Hospital (if applicable):** | | |  | | | |
| **Address:** |  | | | | **Postcode:** |  |
| **Telephone number:** | |  | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service:** |  | | | **Contact Name:** |  | |
| **Hospital (if applicable):** | | |  | | | |
| **Address:** |  | | | | **Postcode:** |  |
| **Telephone number:** | |  | | | | |

**Mental Health Diagnosis (if applicable)**

|  |
| --- |
|  |

**Medication Name(s) and Dosage (if applicable)**

|  |
| --- |
|  |

**Further Information**

|  |
| --- |
| **Does this person have any of the following:** (please specify)  Learning difficulties  Physical difficulties  Self-harm  Risk to others  Risk from others  Alcohol problems  Drug problems  **Please attach CPA documents if applicable** |
| *Reason for referral/support required from Mary Seacole House?* |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Referred by Name:** | | | |  | | |
| **Job Title:** | |  | | | **Organisation:** |  |
| **Contact No.:** | | |  | | | |
| **Email:** |  | | | | | |

**Where did you hear about us?**

Friend/Family Member  GP Surgery  Leaflet

Other Health Care Professional  Google/Website/Social Media  Other

**How would you like us to keep in contact with you?**

Telephone call  Text message  Email  Post

I consent to MSH using the personal information provided detailed in this form to assess my needs for access to their services.

I consent to MSH sharing the personal information detailed in this form with its funders (which includes Liverpool City Council) for monitoring and evaluation purposes.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client name:** |  | | **Client signature:** |  | |
| **Form completed by:** | |  | | **Date** |  |