**Worcestershire Community Wellbeing Peer Supporter Service Referral Form**

All entries marked with **\*** are have to be completed. If they are not completed, your referral will be returned.

**Date of Referral (DD/MM/YYYY):\***

**Title:\***

Mr Mrs Miss Ms Dr

Other:

**First Name:\***

**Surname:\***

**Date of Birth (DD/MM/YYYY):\***

**Address:\***

**Post Code:\***

**Preferred Telephone Number:\***

**Secondary telephone number:**

**Email Address:**

**Preferred Method of Contact:\*** Post  Phone  Email

**Has the patient given consent to share this information?:\*** Yes  No

**Name of Referrer:\***

**Referrer’s Email Address:\***

**Referrer’s Contact Number:\***

**Has a risk assessment been carried out?\*** Yes  No

**If a risk assessment has not been carried out, please complete one before continuing with this referral.**

**Reason for Referral:\***

**Any Long Term Conditions?:\*** Yes No

**If ‘yes’, please detail below:**

**Please provide a brief summary of the patient’s conditions and needs and anything else you feel we should know:\***

**Are there any risk factors that we need to be aware of when working 1-1 with this patient?:\***

Yes  No

**If ‘yes’, please detail below:**

**Demographic Information**

**Gender:\*** Male  Female  Other

**If ‘other’, please detail below:**

**What is the patient’s current employment status?:\***

Employed  Unemployed  Full-time Student

Retired  Long Term Sick or Disabled  Full-time Carer

Full-time Homemaker  Not stated

**What is the patient’s ethnicity?:\***

**White**White British  White Irish  Any Other White Background

**Mixed**   
White & Black Caribbean  White & Black African  White & Asian

Any Other Mixed Background

**Asian or Asian British**Indian  Pakistani  Bangladeshi  Any Other Asian Background

**Black or Black British**Caribbean  African  Any Other Black Background

**Other Ethnic Group**Chinese  Any Other Ethnic Group

Not Stated

**Disability**

Would the patient consider themselves to have a disability?:**\***

Yes  No

**If ‘yes’, please detail below:**

Long term mental health issues

**Which Peer Supporter Service are you referring to:?\***

Bromsgrove  Malvern  Redditch  Worcester

Evesham  Pershore  Droitwich  Wyre Forest

**Once completed, please email this form to one of the below Peer Supporter Service you are referring to. Please ensure the subject header states: ‘Peer Supporter Service Referral’**

**Evesham** – Springfield Mind [jennie.reeves@springfieldmind.org.uk](mailto:jennie.reeves@springfieldmind.org.uk)

**Pershore** - Springfield Mind [jennie.reeves@springfieldmind.org.uk](mailto:jennie.reeves@springfieldmind.org.uk)  
  
**Droitwich** - Springfield Mind [jennie.reeves@springfieldmind.org.uk](mailto:jennie.reeves@springfieldmind.org.uk)  
  
**Wyre Forest** – Wyre Forest Mind [tim.salter@nhs.net](mailto:tim.salter@nhs.net) (currently not working - please contact: tim.salter@dudleymind.org.uk)  
  
**Malvern** – Onside [onside.worcs@nhs.net](mailto:onside.worcs@nhs.net)  
  
**Bromsgrove** – Onside [onside.worcs@nhs.net](mailto:onside.worcs@nhs.net)  
  
**Worcester** – Onside [onside.worcs@nhs.net](mailto:onside.worcs@nhs.net)  
  
**Redditch** – Sandycroft [sandy.croft@nhs.net](mailto:sandy.croft@nhs.net)