**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[x]  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 [x]  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 [x]

**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 [x]  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

**Pershore** - Springfield Mind jennie.reeves@springfieldmind.org.uk

**Droitwich** - Springfield Mind jennie.reeves@springfieldmind.org.uk

**Wyre Forest** – Wyre Forest Mind tim.salter@nhs.net (currently not working - please contact: tim.salter@dudleymind.org.uk)

**Malvern** – Onside onside.worcs@nhs.net

**Bromsgrove** – Onside onside.worcs@nhs.net

**Worcester** – Onside onside.worcs@nhs.net

**Redditch** – Sandycroft sandy.croft@nhs.net