**Consent/referral form for the Telephone Support Line**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client details | | | | | |  | | | |
|  | |  | |  |  | |  | |
| Name and surname |  | | | | | Ethnicity | |  | |
| Preferred pronouns/name |  | | | | | Address | |  | |
| DOB |  | | | | | Post code | |  | |
| Phone Number |  | | | | | Email | |  | |
| **Details of person making referral if not self-referral and contact email/telephone number:** | | | | | |  | | | |
|  | | | | | | | | | |
| Support network and personal info | | | | | | | | | |
| GP surgery name and  contact address  **Consent to contact GP** | | | YES/NO | | | | | | |
| Reason for referral (please include your mental health history and how you feel the Telephone Support Line can support you) | | |  | | | | | | |

X local Mind  
Address line 1

Address line 2

Town, POSTCODE

|  |  |
| --- | --- |
| How can we contact you? | |
| Telephone |  |
| Virtual (for example, Zoom) | Email |

|  |  |  |
| --- | --- | --- |
| Administrative information: | | |
| Do you have any additional mental health and/or physical health conditions that you would like to share with us? |  | |
|  | |  |
| Consent: | |  |
| Is it ok for us to share information regarding yourself with other professionals/agencies? | | **YES/NO** |
| If we believe that you may be at risk of immediate and serious harm to yourself or others we may have to involve emergency services to carry out a welfare check to ensure your safety. | | |

I consent to Norfolk and Waveney Mind holding my contact details as pertaining to the Telephone Support Line only: **Yes/No**

Would you like to be kept up to date with events that Norfolk and Waveney Mind may be hosting? **Yes/No**

**Print name:**

**Signed:**

**Date:**