|  |  |  |  |
| --- | --- | --- | --- |
| **Referral Date** |  | **Completed by** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Last referral date**  **D** |  | **Last Discharge Date** |  |

**PERSON DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name(s)** |  | **DOB** | **/**  **/** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Sex** | Male  Female  |

|  |  |  |  |
| --- | --- | --- | --- |
| **NHS Number** |  |  |  |

**ADDRESS/CONTACT DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Address 1** |  | **Telephone** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Address 2** |  | **Mobile** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **City/Town** |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **County** |  |  | **Preferred method of contact:** |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Post Code** |  |  | Letter  Phone call  |  |  |  |  |  |

**NEXT OF KIN**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Telephone** |  |

|  |  |
| --- | --- |
| **Address** |  |

**GENERAL PRACTITIONER**

|  |  |  |  |
| --- | --- | --- | --- |
| **GP Surgery** |  | **GP Name** |  |

**EQUALITY AND DIVERSITY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Nationality** |  | **Language** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Ethnicity** |  White British   Mixed - White & Black Caribbean   Asian/Asian British - Indian   Black/Black British - Caribbean   Chinese |  White Irish   Mixed - White and Black African   Asian/Asian British - Pakistani   Black/Black British - African   Other Ethnicity – Please state: |  White Other   Mixed - Other   Asian/Asian British - Other   Black/Black British - Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **Sexuality** |  | **Religion** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Disability** |  No disability   Sight   Speech   Hearing |  Mobility and gross motor   Manual dexterity   Progressive conditions/physical health   Behaviour and emotional |  Learning disability   Perception of physical danger   Personal, self-care and continence   Other |

**Information and communication needs** Give details of any info/communication needs (e.g. interpreter required, large-print, BSL, induction loop)

|  |  |
| --- | --- |
|  |  |

**REFERRER**

*Details of the person making this referral if not the person named above.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of referrer:** |  | **Agency (if professional):** | **/**  **/** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Relationship to client:** |  | **Contact Number:** | **/**  **/** |

|  |  |  |
| --- | --- | --- |
| **Drug/alcohol use**  *Give details of:*   * *any current/recent/past drug or alcohol use* * *any previous drug/ alcohol treatment received* |  |  |

|  |  |  |
| --- | --- | --- |
| **Physical/Mental Health**  *Give details of:*   * *physical health issues* * *mental health issues* * *prescribed medications* * *involvement with mental health services* |  | **Are you receiving treatment for any physical health problems? If yes what…** |

|  |  |  |
| --- | --- | --- |
| **Carers**  *Are you a carer for someone? Is someone a carer for you? Give details.* |  |  |

|  |  |  |
| --- | --- | --- |
| **Family/Carer Involvement**  *Unity encourage the involvement of family members/carers in your treatment. Who would you like to have involved in your support?* |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Armed Forces Status** |  |  Current reservist personnel   Ex-reservist personnel |  Current serving personnel   Ex-serving personnel |  Family of personnel   Not applicable |

|  |  |  |
| --- | --- | --- |
| **Other relevant info**  *Give brief details of:*   * *criminal justice involvement* * *housing* * *education/employment* |  |  |

**Family & Children**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Childs Name** | **D.O.B** | **Address** | **GP** | **Relationship** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Referrals can be made in person, over the phone, by post, fax or e-mail:

|  |  |  |  |
| --- | --- | --- | --- |
| **Office** | **Address** | **Telephone** | **Fax** |
| Carlisle | Unity, 1st Floor, Stocklund House, Carlisle, CA3 8SY | 01228 212060 | 01228 535681 |
| Workington | Unity, 6 Finkle Street, Workington, CA14 2AY | 01900 270010 | 01900 873136 |
| Whitehaven | Unity, 21b Lowther Street, Whitehaven, CA28 7DG | 01946 350020 | 01946 591391 |
| Barrow | Unity, 92-96 Duke Street, Barrow, LA14 1RD | 01229 207020 | 01229 615659 |
| Kendal | Unity, White Horse Yard, 39 Stricklandgate, Kendal, LA9 4LT | 01539 742780 | 01539 739420 |

unity@gmmh.nhs.uk

|  |
| --- |
| **Office use**  Form completed by:  Appt Date/Time: |