RAMH
recovery across mental health

REFERRAL FORM

Email:**referrals@ramh.org** • Admin Co-ordinator:**41 Blackstoun Road, Paisley PA3 1LU** • Tel:**0141 847 8900**

If you know the service you require please tick the appropriate box:

- ☐ Causeway Community
- ☐ Causeway Employability
- ☐ East Renfrewshire Adult Counselling
- ☐ ERYCS
- ☐ Employability (Renfrewshire)
- ☐ FIRST Crisis
- ☐ Information (East Renfrewshire)
- ☐ Information (Renfrewshire)
- ☐ Lifeskills/Re-Use Store
- ☐ Renfrewshire Community Service
- ☐ Community Link

Housing: ☐ Ayr North ☐ East Renfrewshire ☐ Renfrewshire

PERSONAL DETAILS

Title:	First Name:	Surname:
DOB:	Gender:	
National Insurance No. (if known):		
Address:		
		Postcode:
Tel No. (H):	Tel No. (W):	Mobile No.:
Email Address:	School:	Year:

Is it ok to contact the person by phone/letter/email at home/work/mobile?

Home: ☐YES ☐NO Work: ☐YES ☐NO Leave a message: ☐YES ☐NO

Mobile: ☐YES ☐NO Letter to Home: ☐YES ☐NO Ok to identify service: ☐YES ☐NO

Email: ☐YES ☐NO Concent SMS: ☐YES ☐NO GDPR Confidentiality: ☐YES ☐NO

GP:..... GP Telephone No: .....

Actual Name of Practice: ..... CHI Number: .....

MEDICATION

Is the person taking any form of medication? ☐ YES ☐NO

If so please indicate what type.....

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Is the person being prescribed any drugs to assist them with their mental health problems? ☐ YES ☐NO

If so please indicate what type.....

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☐ Anti-Psychotics ☐ Anti-Depressants ☐ Other (please specify) .....

REFERRER DETAILS

Referrer:	Occupation/Relationship to service user:	
Address:		
		Postcode:
Tel No.:	Fax No.:	Email:

Is the person aware of the service and in agreement to the Referral? ☐ YES ☐ NO

Is the young person willing to attend the service? ☐ YES ☐ NO

If a young person, are their parent /guardian aware of referral? ☐ YES ☐ NO

Other Supports ☐ YES ☐ NO

Agency:	Contact:	Tel:
Agency:	Contact:	Tel:
Agency:	Contact:	Tel:

Reasons for Referral, including support guidelines or action to be taken if RAMH staff have any concerns:

Please tick ALL OF THE REASONS that best describes the person's reasons for seeking support at this time.

- ☐ Abuse
- ☐ Addictions Drugs/Alcohol
- ☐ Adverse Childhood Experiences
- ☐ Anger Issues
- ☐ Anxiety/Stress
- ☐ Bereavement/Loss
- ☐ Bi-Polar Illness
- ☐ Bullying
- ☐ Carer
- ☐ Cognitive/Learning
- ☐ Covid
- ☐ Depression
- ☐ Eating Issues
- ☐ Family Issues
- ☐ Interpersonal/Relationship difficulties
- ☐ Living/Welfare/Housing
- ☐ Loneliness
- ☐ Personality/Challenging Behaviour
- ☐ Physical Health/Illness
- ☐ Pregnancy
- ☐ Psychosis
- ☐ School Issues
- ☐ Self-Harm
- ☐ Suicidal Ideation/Behaviour
- ☐ Trauma
- ☐ Work/Academic/Training
- ☐ Other (please state)

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RISK ASSESSMENT, SAFEGUARDING OR PROTECTION ISSUES

Do you know of any areas of risk/concern that RAMH should be aware of ☐ YES ☐ NO

Please provide details, including guidance on what action, e.g. FIRST Crisis should take, if they are unable to make initial contact with the service user, is there anyone you would like us to contact?:

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Living Arrangements

- ☐ Carer role in household
- ☐ Caring for Children
- ☐ Living alone
- ☐ Living in homeless unit
- ☐ Living in residential/secure accommodation
- ☐ Living in supported accommodation
- ☐ Living with foster care
- ☐ Living with parents/guardian
- ☐ Living with other relatives/friends
- ☐ Looked after at home
- ☐ Other (please specify)

Does the person have any medical/health conditions? ☐ **YES** ☐ **NO**

Please give details .....

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Can Referrer please tick if you have discussed Self Directed Support (SDS) options, and which option 1-4

SDS Option ☐ 1 ☐ 2 ☐ 3 ☐ 4

ETHNICITY

- ☐ Asian or Asian British
- ☐ Black or Black British
- ☐ White or White British
- ☐ Mixed Background
- ☐ Other Ethnic Group (type here) _____

Signature: ..... **Date Referred:** .....

RAMH operates a confidential and secure service and is registered under the Data Protection Act and are GDPR Compliant. The information you provide will be processed by computer. You may have access to information on written request.

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