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:

East Renfrewshire:

- ☐ Community Services
- ☐ Community Link
- ☐ Counselling
- ☐ Employability
- ☐ Housing Support
- ☐ Information
- ☐ Youth Counselling
- ☐ Restore

Renfrewshire:

- ☐ Community Services
- ☐ Employability
- ☐ Housing Support
- ☐ Information
- ☐ FIRST
- ☐ Restore

North Ayrshire:

- ☐ Recovery College

PERSONAL DETAILS

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

Ethnicity:

☐ Asian or Asian British ☐ Black or Black British ☐ White or White British

☐ Mixed Background ☐ Other Ethnic Group (type here) .....

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 Consent SMS: YES NO GDPR Confidentiality: YES NO

Other Supports ☐ YES ☐ NO

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

PERSONAL DETAILS (cont.)

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 partner
- ☐ Living with other relatives/friends
- ☐ Looked after at home
- ☐ Other (please specify) .....

GP:	GP Telephone No:
Actual Name of Practice:	CHI Number
Does the person have any medical/mental health conditions? ☐ YES ☐ NO	
Please give details :	
Is the person taking any form of medication? ☐ YES ☐NO	
If so please indicate what type:	

REFERRAL DETAILS

Referrer:	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		
Reasons for Referral, including support guidelines or action to be taken if RAMH staff have any concerns:		
Can Referrer please tick if you have discussed Self Directed Support (SDS) options, and which option 1-4 **SDS Option** ☐ 1 ☐ 2 ☐ 3 ☐ 4		

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
- Depression
- Eating Issues

REFERRAL DETAILS (cont.)

- 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?:

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

Appointment Date: .....

Appointment Time: .....

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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