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citizens advice East Berkshire

Referral form for CAEB Mental health Project

Referrer	
Name:	Team/Service:
Phone:	Email:
Client	
Name:	Address:
Phone:	Council Tax authority:
Email:	D.O.B.:
Date of referral:	In-patient?
Consent	
Does client consent for their personal and health details to be shared with Citizens Advice East Berkshire? Yes ☐ No ☐	
Is client aware that a referral has been made? Yes ☐ No ☐	
GP surgery:	
Health (Does client have severe mental health issues or experiencing significant mental health distress?) If yes, please elaborate:	
Diagnosis	
Risk Please indicate any risk or issues in relation to the following: **(Where risk indicated, please attach latest risk assessment)**	
Visiting CAEB service in person:	
Outreach and lone working:	
Subject issues	
Benefits	
Debt	
Housing	
Health services and community care	
Other	