Referral form for CAEB Mental Health Project

Referrer	
Name:	Team / Service:
Phone:	Email:
Client	
Name:	Address:
Phone:	
Email:	Date of Birth:
Date of referral:	In-patient? Mark relevant box with an **X** or tick ☐ Yes ☐ No
Consent	
Does client consent for their personal and health details to be shared with and recorded by Citizens Advice East Berkshire? Please mark relevant box with an **X** or tick ☐ Yes ☐ No Is client aware that a referral has been made? ☐ Yes ☐ No Is this referral urgent i.e. deadline on benefit claim/imminent homelessness ☐ Yes ☐ No (please elaborate in subject boxes below)	
GP surgery (name and address):	
Health (Does client have severe mental health issues or experiencing significant mental health distress?) If yes, please elaborate:	
Diagnosis of mental health condition:	
Risk/ relevant support needs Please indicate any risk or issues in relation to the following: (Where risk indicated, please attach latest risk assessment) **Visiting CAEB service in person:** **Support needs required e.g. translator/BSL/illiterate/sight impaired:**	

Subject issues – brief explanation of client's issue/s
Benefits
Debt
Housing