Birmingham Mental Health Recovery & Employment Service – Referral Form

enabling people with mental health challenges

Details of Person Being Referred	
Title: _____	First Name: Surname:
Date of Birth:	
Address:	
	Postcode:
Contact numbers:	
Email:	
NHS Number:	
Gender:	Male / Female / Prefer not to Say

Reason for Referral
Description of mental health condition:
What wishes for recovery support or pre-employment support and/or employment has the service user expressed?
Has the Service User expressed a wish for employment only? Yes No
If the Service User has expressed a wish for employment, please set out any education/training/volunteering/work experience needs agreed and the service user's preferred approach to meeting these needs
Is the referral for a Military Veteran/current member of Armed Forces? Yes No

Referrer Details
BSMHFT: ◯ FTB CORE: ◯ FTB EI: ◯
Team Location:
Name of Referrer:
Contact Number:

Key Mental Health Professional's Details (CPN/OT/GP)	
Name:	
Role:	
Tel. No:	

GP Details		Emergency Contact	
GP Name:		Name:	
Surgery Name:		Relationship:	
Tel. No:		Tel. No:	
Named Carer:		Address:	

Service User Support Requirements

Please confirm support requirements, including disabilities, that need to be considered when planning the service user's appointment with IPS/Recovery Hub teams

To be accompanied by a friend/carer: ☐ Appointment on a specific day: ☐

Appointment at a specific time: ☐ Appointment at a specific location: ☐

Support with speech or language: ☐ Visual impairment: ☐

Hearing impairment: ☐ Physical disability: ☐

Learning disability: ☐

Please specify the nature of the support required (e.g. hearing loop system, braille, large fonts, interpreter, wheelchair access) and the actions that need to be taken by IPS/Recovery Hub teams if known, or confirm how best to agree these with the service user in advance of the appointment

Risk Information

This section MUST contain a comprehensive summary of relevant risks that need to be considered by IPS/Recovery Hub teams when planning the appointment

Risks	Yes/No	Historical/ Current	Notes/Detail
Suicide			
Self harm			
Self-neglect			
Harm to others			
Harm from others			
Disengagement from services			
Risk to children			
Forensic history			
Substance misuse			
Accidents			
Risks associated with physical health			

***please note, you may be contacted to discuss these risks further before the patient is offered an appointment**

Consent

Has the person being referred consented to this referral? Yes: ☐ No: ☐

Has the person being referred consented to sharing their information? Yes: ☐ No: ☐

I understand that my information and clinical record will be shared between the four organisations, NHS, Better Pathways, MIND and Creative Support

(If you are filling in this form on behalf of a patient, please sign to confirm you have explained the information sharing as stated above)

Patient's Name: _____ Date: _____

Patient's Signature: _____

Please submit referrals to MHRE Administrator Wayne Myles at wayne.myles@nhs.net from another secure NHS email account. If you do not have this facility, please provide the referral by post to: Better Pathways, 201 – 206 Alcester Street, Digbeth, Birmingham, B12 0NQ