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| The Liverpool LightDigital Self-Referral Form |
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| Please take as much time as you need to fill out this form. If you would like any support, please ask a Staff member and they will be happy to assist you. If you would prefer to complete the form online, please scan the QR code below with your mobile phone. |
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| **Referrer Details**If you are self-referring please tick no and ignore the rest of the section. |
| **Are you completing this referral on behalf of someone else?** | Yes |  | No |  |
| **If Yes, what is your relationship to the referee?** |  |
| **If you are a professional referring on behalf of someone you support, what is your job title and organisation?** |  |
| **Has the person consented to this referral?** | Yes |  | No |  |
| **Is it safe to contact this person?**  | Yes |  | No |  |
| **What is the best method of contact?** | Phone |  | Email |  |
| Please provide your contact information below. |
| **Email** |  | **Phone** |  |
| Please note we can confirm receipt of the referral, if requested, but cannot disclose if the individual has accessed or is currently accessing our service, without the individuals consent to share this information.We will only contact you if we require any further information, or have no way of contacting the referee.  |
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| **Referee’s Details** |
| **First Name** |  | **Date of Birth****(DD/MM/YYY)** |  |
| **Surname** |  | **Pronouns** |  |
| **Preferred Name****(if different)** |  | **Postcode** |  |
| **Address** |  |
| **Email Address** |  | **Phone Number** |  |
| **Preferred Method of Contact** |  |
| **Is it safe for us to contact you?** |  |
| **GP Surgery** |  |
| **GP Contact Number**  |  |
| **Gender** | Male |  | Trans Male |  | Non -binary |  |
| Female |  | Trans Female |  | Agender |  |
| Gender Fluid |  | Prefer not to say |  | Other:  |
| **Sexual Orientation** | Heterosexual |  | Pansexual |  | Queer/Questioning |  |
| Homosexual |  | Asexual |  | Prefer not to say |  |
| Bisexual |  | Demisexual |  | Other: |
| **Ethnicity** | White British |  | White Irish |  | White Other |  |
| Asian British |  | Asian Chinese/Indian/ Bangladshi/Pakistani/Other |  | Mixed/Multiple |  |
| Black British |  | Black Caribbean/African/Other |  | Other: |
| **Employment Status** | Full-time employed |  | Full-time student |  | Unable to work due to illness/disability |  |
| Part-time employed |  | Part-time student |  | Retired |  |
| Self employed |  | Unemployed |  | Other: |
| **Housing Type** | Private renting |  | Housing association/Social housing/Council |  | Temporary Accommodation |  |
| Homeowner/Mortgage |  | Living with family/friends |  | NFA/Homeless |  |
| Student Accommodation/ Halls |  | Supported/Assisted Living |  | Other: |
| **Disability Status** | Deaf/Hearing Impaired |  | Chronic Illness |  | ASD |  |
| Blind/Visually Impaired |  | Mental Health |  | Prefer not to say |  |
| Physical Disability/Mobility |  | Learning Difficulties/Disability |  | Other: |
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| **Do you have a current mental health diagnosis?** | Yes |  | No |  |
| **Please indicate these below:** |
| Anxiety / GAD |  | EUPD |  | Disordered Eating |  |
| Depression  |  | Bipolar Disorder |  | Dissociative Disorder |  |
| PTSD / CPTSD |  | ADHD |  | Prefer not to say |  |
| OCD |  | Schizophrenia |  | Other |  |
| **If ‘Other’ please specify below:** |
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| **Have you attended A+E in the past six months regarding your mental health?** | Yes |  | No |  |
| **When was your most recent A+E attendance?** |  |
| **Are you currently receiving support from primary care services? (e.g. GP, community pharmacy)** | Yes |  | No |  |
| **Have you accessed support from other mental health services? (e.g. YPAS, Crisis Team, CMHT)** | Yes |  | No |  |
| **If ‘ Yes’ please specify below:** |
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| **If you feel comfortable to do so, please indicate below any that apply:** |
| Victim of harassment |  | Substance misuse |  | Self-harm |  |
| Victim of domestic abuse |  | Gambling |  | Suicidal thoughts |  |
| Victim of sexual assault |  | Aggression/Violence towards others |  | Suicide attempts |  |
| Victim of physical assault |  | Sexual offences |  | Prefer not to say |  |
| Victim of hate crime |  | Harassment to others |  | Other |  |
| **If ‘Other’, or if there is anything else you would like to be noted by staff or you feel is important for staff to be aware of, please indicate below:** |
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| **If you feel comfortable doing so, please indicate below your history of self-harm and suicidal ideation, feel free to leave details out where you do not feel comfortable disclosing, simply mark as ‘PNTS’.** |
| **Have you self-harmed in the past 6 months?** | Yes |  | No |  |
| **Have you self-harmed in the past 12 months?** | Yes |  | No |  |
| **If ‘Yes’, by what method?** |  |
| **How often do you have thoughts of self-harm?** |  |
| **How often do you engage in self-harm?** |  |
| **Have you ever experienced suicidal thoughts?** | Yes |  | No |  |
| **How often do you experience suicidal thoughts?** |  |
| **Have you ever attempted to take your life by suicide?** | Yes |  | No |  |
| **If ‘Yes’ when was the most recent attempt?** |  |
| **What method was used?** |  |
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| Thank you for completing this referral form. Please sign below to confirm that all details given are to the best of your knowledge true and accurate, and that you consent for your data to be stored on our secure online system. Please ask a member of staff for a copy of our privacy policy if you would like some more information about how we process and store data. Please note that we have duty of care procedures as required by law, to contact emergency services or the local safeguarding authority if we feel like you are at risk of harm to yourself or others.If you have any other questions feel free to ask the staff for more information.Please return completed forms to us via email at **liverpool.light@creativesupport.org.uk**  |
| **Client Signature** |  | **Date** |  |
| **Referrer Signature** |  | **Date** |  |