Breathing Space Referral Form

Please send complete referrals to : breathingspace@mindinbexley.org.uk Telephone: 020 8303 5816 Option 4

Referrer

Client name

DATE OF BIRTH

GENDER ☐ Male ☐ Female

Addresss and Postcode

Email

Has the client/patient agreed to the referral?

☐ Yes ☐ No

Permission to leave a message ☐ Yes ☐ No

Phone Number

Orbit Resident ☐ Yes ☐ No

Ethnicity

☐ I consent to information supplied in this form to be shared with partner organisations

Reason for Referral: (please provide details/ concerns) Attach any relevant reports from yourself/ other services

.

Suggested client/patient needs:

☐ Advocacy ☐ Employment ☐ Money Advice

☐ Health/Wellbeing ☐ Lesiure/social engagement

☐ Training/Workshops ☐ Welfare rights/housing

Current relevant Medications:

Does the client/patient have any additional needs? ☐ Sensory ☐ Language ☐ ASD ☐ Other ☐ None

Other needs / comments

Interpreter required? (if yes please specify language) ☐ Yes ☐ No Details

Is the client receiving support from other services? ☐ Yes ☐ No Details

Client Patient Risk

Previous suicide attempts ☐ Yes ☐ No

Self Harming ☐ Yes ☐ No

Harm to others ☐ Yes ☐ No

Drug/alcohol misuse ☐ Yes ☐ No

Forensic History ☐ Yes ☐ No

If yes to any, provide details

Referred by

Date of Referral

Position

Contact number

Address

Contact email