Breathing Space Referral Form

Print Form

mind for better mental health in Bexley

Please send complete referrals to : breathingspace@mindinbexley.org.uk Telephone: 020 8303 8932 Option 3 or 07951 149 7382

Referrer | Lot Number

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