**Ealing Pathways (Out of Hospital) Referral Form (to be completed by referrer)**

**Please note:** patients must be referred into the Ealing Pathways service using this template. **Please do not signpost patients to our service.**

The completed template should be emailed to:[**ealingpathways@hfehmind.org.uk**](mailto:ealingpathways@hfehmind.org.uk)

|  |  |  |  |
| --- | --- | --- | --- |
| **Referring professional details** | | | |
| Role: | | Team: | |
| Location where you support client: | | Contact number: | |
| **Eligibility criteria – *Part 1***  **(please tick – patient must meet criteria A and at least one of B & C)** | | | |
| A: Patient is eligible to receive free NHS care | | | |
| B: Patient resides in Ealing (temporarily or permanently), or within 1 mile of Ealing boundary | | | |
| C: Patient lives outside of Ealing but within 1-mile boundary & is registered with an Ealing GP | | | |
| **Eligibility criteria – *Part 2* (please tick - patient must meet one of these criteria)** | | | |
| Care is moving from Secondary Care to Primary Care, and patient is being supported by the Primary Care Mental Health Team | | | |
| Patient has serious and long-term mental health needs, and their care remains in Primary Care | | | |
| Patient has serious mental health needs and can be prevented from moving into crisis by support with practical issues | | | |
| **Patient details** | | | |
| Title: | | Full name: | |
| Date of birth: | | Mobile no: | |
| Address: | | Landline no: | |
| Postcode: | | Email: | |
| Mental health conditions: | | Physical health conditions: | |
| Can client be seen alone?  Yes  No | | Urgency of Case:  Critical (tick if there is a high risk or immediate deadline)  High  Medium  Low | |
| In the space below, please briefly summarise the state of the patient’s mental health at the time of referral and any risk factor that the Pathways team should be aware of: | | | |
|  | | | |
| **Issues client requires support with** | | | |
| Welfare Benefits | Housing | | Finance/debt |

**Equal Opportunities (can be completed by referrer or Mind staff)**

**If you have completed this referral on behalf of someone else due limited communication or lacking capacity around these questions, please indicate:**

Yes  No

**I define myself as:**

Female

Male

Gender Binary

Transgender

Prefer not to say

**Please describe your sexuality:**

Lesbian

Gay

Heterosexual

Bisexual

Questioning

Not known

Other

Prefer not to say

**Please describe your religious beliefs:**

Buddhist

Christian

Sikh

Hindu

Muslim

Jewish

Any other religion

No religion

Not known

Prefer not to say

**Please describe your ethnic origin/background:**

|  |  |
| --- | --- |
| **White** | English/Welsh/Scottish/Northern Irish |
| Irish |
| Irish Traveller or Gypsy |
| Any other white background (please specify) |
| **Mixed Ethnic Groups** | White and Black Caribbean |
| White and Black African |
| White and Asian |
| Any other mixed background (please specify) |
| **Asian/Asian British** | Indian |
| Pakistani |
| Bangladeshi |
| Chinese |
| Any other Asian background (please specify) |
| **Black/Black British** | African |
| Caribbean |
| Any other Black/African/Caribbean background (specify) |
| **Other Ethnic Group** | Arab |
| Any other ethnic group (specify) |
| **Ethnicity Not Known** | Ethnicity not known |
| **Prefer Not to Say** | Prefers not to say |

**Do you consider yourself to have any of the follow:**

Mental ill health

Physical disability

Cognitive impairment

An acquired brain injury

An acquired brain injury

A learning disability

Asperger’s/Autistic Spectrum

Dementia/Alzheimer’s

Sensory impairment

Not known

Prefer not to say