

Referral Form

Name of referral: Date of birth: Gender:

Address:

Mobile number: GP Surgery:

Email:

Does the person have a disability?

Physical ☐ Hearing ☐
Visual ☐ Learning ☐
Other ☐ No ☐

What do you feel the individual needs support with?

Emotional wellbeing ☐ Mental ill health ☐
Bereavement ☐ Drugs, alcohol, or smoking ☐
LGBT+ support ☐ Physical wellbeing, including inactivity or weight management ☐

Services that you feel a person may benefit from attending:

Physical activity groups ☐
Creative arts groups ☐
Social inclusion groups ☐
Peer support for mental health ☐

Are there any other agencies involved?

Is there anything you wish to tell us about the person that you feel may benefit the support they receive?
E.g. Why they are being referred? Any pronouns they prefer to use?

Only to be completed if referral is under 16

Parent name:

Parent contact number/email:

Referring practitioner details

Name of referrer: Date:

Position/organisation:

When complete, please email this form to: ines.pereira1@nhs.net

Please note: This form is for individuals registered with a doctor within the West Herts and Harrow area. This service is **not** for anyone in crisis, for example anyone having suicidal thoughts.