**Barnsley Support Hub- Professional Referral Form**

|  |
| --- |
| Our Barnsley Support Hub provides emotional support and practical information to individuals who may be in crisis or heading towards a crisis situation. These services can also provide information and signposting to broader support services, including those that support with housing, benefits, and debt management and are for clients considered not to require full mental health assessment and/or referral to secondary care mental health services.  Note: \* are mandatory fields |
| **Barnsley Support Hub** |
| **Phone**: 07855 971634 (open hours only) **Hours:** Thursday – Monday, 6 – 11pm  **Email:** [barnsley.mhm@nhs.net](mailto:barnsley.mhm@nhs.net) **Who is Barnsley Support Hub service for?** The service supports clients aged **over 18** and who are living in the Barnsley area |

|  |  |
| --- | --- |
| **Referral details** | |
| \* Today’s Date: |  |
| \* Full name: |  |
| \* Name of service referring from: |  |
| \* Contact number: |  |
| \* Email: |  |

|  |  |
| --- | --- |
| **Client details** | |
| \* Title: |  |
| \* Full name: |  |
| \* Current address: |  |
| \* Date of birth: |  |
| \* Contact number: |  |
| \* Do we have permission to leave a voicemail? |  |
| \* Do we have permission to send an SMS? |  |
| Email: |  |
| \* Gender: |  |
| Ethnicity: |  |

|  |
| --- |
| **Mental Health and Wellbeing** |
| \* Reason for the referral |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Have you experienced any of the following?** | | | | | |
|  | In the last week | In last month | In last year | 1+ years ago | Never |
| Suicidal thoughts |  |  |  |  |  |
| Suicide attempts |  |  |  |  |  |
| Thoughts of self-harm |  |  |  |  |  |
| Cutting or self-harming |  |  |  |  |  |
| Obsessive or compulsive behaviour |  |  |  |  |  |
| Violence or aggression |  |  |  |  |  |
| Bullied by someone |  |  |  |  |  |
| Inappropriate behaviour |  |  |  |  |  |
| If any box, except never, has been checked, please provide further information to help support the client |  | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Submission of Information** | | | |
| By submitting this form, the client agrees to [MHM's Client Privacy Policy](https://www.mhm.org.uk/Handlers/Download.ashx?IDMF=8d306ef5-d4c2-4a5a-9662-51d86a9319ff) and MHM communicating with healthcare professionals (including their General Practitioner) regarding their health care services. Please contact the service if you or the client have any questions. | | | |
| **This form has been completed and submitted with the client’s agreement** | | | |
| \* Referral Person’s Initials: |  | \* Date: |  |

**Thank you for taking the time to complete this form**