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**Wellbeing Team – Community Liaison Service**

**Referral Form**

To be completed by the Health Care Professional

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Referring Professional** | | | | | | |
| **Date of referral:** |  | | | | | |
| **Name:** |  | | | | | |
| **Department:** |  | | | | | |
| Is the individual aware of and agreeable to this referral?  Yes No | | | | | | |
| **Individuals Information** | | | | | | |
| **Name** |  | | | | | |
| **Address** |  | | | | | |
| **DOB** |  | | **Gender** | Female  Male | | Other |
| **Contact Number** |  | | **Email (If known)** |  | | |
| **Next of Kin (If known)** |  | | **Email (If known)** |  | | |
| **Discharged** | Yes  No | | **Estimated Date**  **(If known)** |  | | |
| **Any known Risks?** | No Risk | Risk to Self-Harm | | | Risk to others | |
| **Further details (Optional):** |  | | | | | |