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| **Part A – Referrer Consent** *(to be completed by referrer)* |
| GP surgery: |  |
| Patient name: |  | NHS Number: |  |
| Gender: |  | Date of birth: |  |
| I recommend for the above patient to receive advice and/or social prescriptions from the Gloucestershire Community Wellbeing Service in order to receive support and onward signposting/referral to appropriate local agency/ies. I confirm that I have assessed this patient and to my knowledge there is no medical reason why he/she should not participate. I confirm that I have discussed this referral, and the reasoning for it, with the patient. |
| Referrer Name and Role: |  | Referral Date: |  |
|  |
| **Part B – Referral Information** *(to be completed by referrer)* |
| Support required in relation to (mark with an ‘X’ as many boxes as apply): |
| Mental Health and Wellbeing |  | Housing / Environment |  |
| Social Isolation |  | Long Term Health Conditions |  |
| Loneliness |  | General Health and Fitness |  |
| Debt / Finance |  | Other *(please state)* |  |
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| Reason for referral to the service: |
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| **PLEASE COMPLETE THIS SECTION**  Are there any known risks? \*It is essential this is completed if a home visit may be requested\* |
| History of substance misuse? Any history of aggression/violence or concerns around behaviour  | Smoker Dog(s) at the propertyOther…………………………………………………… |
| Has the patient been referred to any other services or currently working with services? Please state:  |
|  |
| **Part C – Patient Consent** |
| I consent to referral to the Community Wellbeing Service, the nature and purpose of which has been explained by my health or social care referrer. I understand any personal information shared about me will be treated as confidential; it may be used in anonymous form for statistical or research purposes. I understand that I have (i) the right to change my mind about being referred to the service and to withdraw consent and (ii) right of access to my information. I give permission for my GP (and referrer where different) to be kept informed of my progress.  |
| Has the patient given consent to refer them? (please tick box)***\*Consent is required by the patient or their representative for the Community Wellbeing Service to accept referral*** |  |
| Signed by the patient |  |
| Date |  |
| Patient Address |  |
| Patient Contact Number |  |
| Patient Contact Email (optional) |  |
|  |
| **Instructions for referrer:** Please send your Community Wellbeing Service Referral Form using nhs.net to the following e-mail address: **cws.grcc@nhs.net**Phone number for enquiries: 07738 106384 |

**The Cotswolds**

Gloucestershire Community Wellbeing Service and Social Prescription Referral Form