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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)* | | |  |
|  | | | | | | | |
| 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 property  Other…………………………………………………… | |
| 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**](mailto:cws.grcc@nhs.net)  Phone number for enquiries: 07738 106384 | | | |

**The Cotswolds**

Gloucestershire Community Wellbeing Service and Social Prescription Referral Form