**The Cotswolds**

**Gloucestershire Community Wellbeing Service**

***Community/Self-Referral***

**Part A – Details of individual** (to be completed by individual or person referring)

|  |  |
| --- | --- |
| Name: | Date of Birth: |
| Contact number: | Gender: Male Female Transgender  Not Known  Decline to Disclose  Other |
| Address (incl. postcode): | Contact Email:  (optional) |
| GP Practice: | |
| NHS Number (if known): | |

**Part B- Referral Information**

**Support required in relation to** (please select all that apply):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Caring Responsibilities |  | Debt/Finance |  | Employment |  |
| Loneliness |  | Social Isolation |  | Welfare Check |  |
| General Health & Fitness |  | Housing/Environment |  | Mental Health & Wellbeing |  |
| Long Term Health Conditions |  | Other (please specify) |  |  | |
| **“What Matters To Me”**  What support do you/the person you are referring hope to get from the Community Wellbeing Service? | | | | | |
| *Please give any other relevant referral information that will help the Community Wellbeing Service provide support.* | | | | | |

**Do you/they experience any of the following?** (please select all that apply):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hearing difficulties |  | Communication difficulties |  | Sight loss |  |
| Requires an interpreter |  | Other (Please specify) |  |

**Are you/they in contact with of the services below?** (please select all that apply):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| NHS Mental Health |  | Social Care |  | Other (Please specify) |  |

**Part C- Risk Assessment**

\**Is there anything the service needs to know about in case a home visit is required?*

|  |  |
| --- | --- |
| Are you/they at risk from others or vulnerable in any way? If so please specify below: | Are there any risks associated with where you/they live? (e.g. dogs at the property, partner etc.) If so please specify below: |
|  |  |

**Part D- Consent**

**To be completed by person referring (if applicable)**

|  |  |
| --- | --- |
| Referrer Name: | Date of Referral: |
| Referrer contact number/or email: | |
| Relationship to person being referred (or organisation, if applicable): | |

**To be completed by person being referred**

I consent to referral to the Community Wellbeing Service. I understand that any personal information shared about me will be treated as confidential in line with Data Protection Act and that it may be used in anonymous form for statistical or research purposes.I understand that I have the right to (i) withdraw my consent and (ii) access my information. I give permission for my GP (and referrer where different) to be kept informed of my progress.

**Please CLICK to tick box to indicate consent to refer**

***\*Consent is required for the Community Wellbeing Service to accept referral***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature of person being referred: | | | | |
| **OR** Please confirm verbal consent given by marking with an ‘X’: | **YES** |  | **NO** |  |
| Today’s Date: | | | | |

|  |  |
| --- | --- |
| **Referrals can be made by email or phone.** | |
| E-mail address: | [**cws.grcc@nhs.net**](mailto:cws.grcc@nhs.net) |
| Phone number | 07738 106384 |