**Professional Referral – referring a client or a patient to Growing Well**

Growing Well is a mental health charity that works with people to improve their mental health through occupational focus. We provide supported physical activity on our field plus training and therapeutic support delivered through a Goals Based Outcomes Framework. Our service operates on weekdays from 9am to 5pm and beneficiaries attend on one regular day per week for up to a year.

Please complete this form and send to [refer.egremont@growingwell.co.uk](mailto:refer.egremont@growingwell.co.uk) or post to Growing Well West Cumbria, Beck Green, Cross Side, Egremont CA22 2AP

**Please consider, before completing this form, whether your reason for referring an individual is primarily and directly related to their mental health.**

**Professional providing the referral**

|  |  |
| --- | --- |
| **Date** |  |
| **Name** |  |
| **Profession** |  |
| **Workplace name& address** |  |
| **Contact telephone number** |  |
| **Email** |  |
| **Relationship to individual being referred** |  |

**The individual being referred**

|  |  |
| --- | --- |
| **Name** |  |
| **Date of birth** |  |
| **Gender** |  |
| **Full address and postcode** |  |
| **Telephone** |  |
| **Email** |  |
| **Preferred method of contact** |  |
| **Mental health diagnosis (if relevant)** |  |
| **Do you know if this person has received, or is currently receiving, support from mental health (or other) services?** | Yes  (Please specify which service(s)):  No  Don’t know |
| **Is this person taking any medication linked to their mental health condition?** | Yes  (Please specify medication)  No  Don’t know |
| **Does this person have any other medical conditions that we should be aware of, in relation to the activity?** | Yes  (Please specify):  No  Don’t know |
| **Is there a known risk of aggression/violence?** | Yes  (please specify):  No  Don’t know |
| **If yes, who is this risk directed to?** |  |
| **Is there a risk to lone workers/staff?** | Yes  No  Don’t know |
| **Does the person have any criminal convictions?** | Yes  (please specify):  No  Don’t know |
| **Is the person registered under the Sex Offenders Act 1997?** | Yes  (please specify):  No  Don’t know |
| **Is the person a regular user of alcohol or drugs?** | Yes  (please specify):  No  Don’t know |
| **Does the person self-harm / have suicidal ideation?** | Yes  (please specify):  No  Don’t know |
| **Is the person working with any other agencies to reduce risk to self or others?** | Yes  (please specify):  No  Don’t know |

**Thank you for your referral. We aim to contact prospective beneficiaries within 3 working days of receipt of this form.**

**If we are unable to make contact with the individual after 2 weeks of receipt of this referral, the referral will be considered void and we will contact you to inform you of this.**

**If you are unable to answer all questions (or need to answer “Don’t Know” to any questions), we will require a further reference from another professional in order to gather all information and progress the individual’s admission to Growing Well.**