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**THIRD-PARTY REFERRAL FORM**

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| **Referral Date:** |  |

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| **Referrer Details** |
| **Referrer Full Name:** |  |
| **Role/Organisation:** |  |
| **Telephone Number:** |  |
| **Email:** |  |
|  | **Please check below to confirm ✓** |
| **I confirm that the person being referred has given consent for the referral and for their personal information and contact details to be shared with Derbyshire Recovery Partnership.** |  |
| **I confirm that the person being referred has given consent for the information I provide to be recorded on the client’s NHS record. The information will be restricted however healthcare professionals will see that the client is open to our care.** |  |
| **I confirm that the person being referred has given consent to be contacted by Derbyshire Recovery Partnership via the contact details provided.** |  |

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| **Client Details** |
| **First Name:** |  | **Surname:** |  |
| **Date of Birth:**  |  | **NHS Number if known:** |  |
| **Address:** |  |
| **Landline:** |  |
| **Mobile:** |  |

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| **Brief details about the reason for the referral:** |

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| **Are children's social care involved?** | **YES / NO** |
| **If yes; detail any additional information regarding risk here:** |
| **Has the client previously served in the UK armed forces (including TA)?** | **YES / NO** |

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| **Additional referral information:** |

Thank you for your referral. We will attempt to contact the person by phone and text to complete their referral. If we are unsuccessful, they will be sent a contact letter and information about the service inviting them to get in touch.

**Please telephone or send the referral to the Single Point of Contact HUB**

HUB Secure Email: dhcft.daas@nhs.net Telephone: 01246 206 514