****

**THIRD-PARTY REFERRAL FORM**

|  |  |
| --- | --- |
| **Referral Date:** |  |

|  |  |  |
| --- | --- | --- |
| **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.** | |  |

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

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

|  |  |
| --- | --- |
| **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** |

|  |
| --- |
| **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](mailto:dhcft.daas@nhs.net) Telephone: 01246 206 514