**Before Making this referral**

Please be aware, we are not a crisis service and referrals made to our team are not always read straight away. If you feel you are experiencing a mental health crisis and there is a risk to your life, or someone else, please call 999.

**If you require urgent support, please speak to:**

* Your GP, 111 or A&E
* The Samaritans 116 123
* SANELine 0300 767 8000 *(4:30 pm –10:30 pm daily)*
* Childline 0800 1111 *(If you are a young person)*
* CALM 0800 58 58 58 *(for men)*

**About us**

* We are an Early Intervention Team within Essex County Council, working with adults aged 18-65, who live in Essex, where Mental Health is the main and primary concern.
* Every person is unique, therefore how we work with each person is different. The support we provide is always led by the person and based on the person giving their informed consent.
* MHWT cannot accept referrals where the adult is receiving a service from secondary mental health services, which are NHS Mental health Services such as Essex Partnership University Foundation Trust (EPUT).

|  |  |  |
| --- | --- | --- |
| **SECTION 1 – Contact details** | | |
| Name |  | | | DOB | |  |
| Address |  | | | Contact/Telephone: | |  |
| Email Address |  | | | Do we have permission to leave a text message or a voicemail? | |  |
| **Is there any other information we need to know about?**  *(Eg: Communication Needs, Additional Mobility/Access Needs, Cultural Needs, Special Requirements, Carer, Employment, etc)* | | | | | Yes / No / NK  /  / | |
| **If yes, please explain** | |  | | | | |

|  |  |
| --- | --- |
| **SECTION 2 – Requester Details**  *(If not Self-referral)* | |
| Name |  | | Professional Role |  |
| Address  *(Please include postcode)* |  | | Agency |  |
| Email Address |  | | Contact Details |  |
| **I have provided a copy of my agency risk assessment document**  (It is essential you attach an up to date Assessment and Risk Assessment. We will ask for this before we contact the adult, so please attach it with this referral) | | | | Yes  No |

|  |  |
| --- | --- |
| **SECTION 3 – Agencies Involved**  *(Please describe any support in place and involvements)* | |
| GP |  | Housing |  |
| Social Services |  | Health/Medical (except GP) |  |
| Voluntary/  Charities |  | Others |  |

|  |  |
| --- | --- |
| **SECTION 4 - Reason for Referral** | |
| *Where did you hear about us?* |  | |
| What are the Mental Health Issues you have and how long have they been an issue? |  | |
| What specific goals do you hope to achieve by working with us? |  | |
| What do you do already, no matter how small it may seem, that helps you to manage?  *(For example, either a person, service or skill)* |  | |
| Is there anything about your mental health that particularly worries you?  *(Thoughts, feelings, emotions, actions, behaviours, etc…)* |  | |
| Anything else you want to tell us about? |  | |

|  |  |
| --- | --- |
| **SECTION 5 – The Adult’s Agreement**  **to Share Information** | |
| **This page is to be completed once you have gained consent from the adult to submit this request**  Please read carefully, then sign and date the form. If you have concerns, please discuss them with the MHWT service or with the person completing the form with you.   * **I agree** that personal information about me may be shared with or requested from other agencies (section 3) and with other professionals, so that my needs can be assessed, or I can be provided with services. * **I agree** that personal information about me can be used for research to develop local and national practice (which will be suitably anonymised) and contribute to understanding needs across Essex. * **I agree** that personal information about me may be shared with or requested from other professionals, so that I can be provided with services which I may benefit from. * **I understand** that I have the right to restrict what information may be shared and with whom, however information can be shared without consent in order to safeguard the vulnerable, to prevent crime and/or if ordered by a Court. * **I understand** that I may withdraw my consent to share information at any time – your key worker will arrange a discussion with you around the effects of this decision.   *Note: In order to alter your consent, please inform the person working with you. This consent form should be reviewed at the completion of any new assessment to ensure it remains an accurate reflection of the families’ wishes.* | | | | |
| Full Name of the Adult |  | | | |
| Signature of the Adult |  | | Date |  |

**How to send this Form**

*We are contactable Monday to Friday, between 10:00am and 4:00 pm*

*Please call the Referral Coordinator to discuss this referral or if you have any questions on*

*033303 22958*

**By Email to:** mentalhealth.wellbeingservice@essex.gov.uk

**By Post to:**

Mental Health and Wellbeing Team

C328-9 County Hall

Market Road

Chelmsford, Essex

CM1 1QH