|  |  |
| --- | --- |
| **Staying Well Referral Form – easy read**  **Phone number: 0800 023 6475**  To be completed and returned to:   * Brighton: [stayingwell.brighton@southdown.org](mailto:stayingwell.brighton@southdown.org) * Eastbourne: [stayingwell.eastbourne@southdown.org](mailto:stayingwell.eastbourne@southdown.org) * Hastings: [stayingwell.hastings@southdown.org](mailto:stayingwell.hastings@southdown.org) |  |
| The Staying Well service offers support to individuals that feel they are no longer able to cope. Please use this form to refer someone for early crisis intervention. |  |

To make a referral to Staying Well please complete and return the form below:

|  |  |
| --- | --- |
| Days | **Date of Referral**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Referrer**

|  |  |
| --- | --- |
| Name5 | **Name of Referrer**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| ID Badge 3 | **Profession and organisation** |
| Email Address  Phone Number Home | **Email**  **Telephone Number** |

**Patient/Client details**

|  |  |
| --- | --- |
| Name5 | **Name**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Gender Male Female | **Gender**  **Male 🞏 Female 🞏**  **Other *(please state)***  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Months | **Date of Birth** |
| Envelope write | **Address** |
| Email Address  Phone Number Home | **Email**  **Telephone Number** |
|  | **Next of Kin / Emergency Contact Number** |
| Mother Daughter 3 | **Do they have a carer  or are they a carer themselves  ?**  **Carers name:** |

**Other professionals**

|  |  |
| --- | --- |
| GP Doctor 1 | **GP name and surgery (if referral from other professional):** |
| Talk and listen | **Psychiatrist details/ other mental health professional(s) involved:** |

**Reason for the referral**

|  |  |
| --- | --- |
| Health meeting 1 | **Please describe the reason for the referral (the current situation, any relevant background information, presenting difficulties, risks and your recommendation):** |
| Care Provider 1 | **Where would you have usually referred your patient/ client if Staying Well had not been available?**  **Primary Care / GP  Haven, MHRRS, Lighthouse  Wellbeing & Secondary Care  Ambulance (SECAMB)  ASC  A&E  Crisis Team  Police  Other** |
| BSL Communicate | **Does the patient/ client have any communication needs or restrictions?** |
| Family 1 | **Does the patient/ client want family, friends or carers involved in their care and support? Please give details:** |
| Good News Meeting | **Has the client consented to family, friends or carers being involved?** |
| Check Directions 3 | **Does the patient/ client need additional support to help them access services?**  (We are able to provide maps on request showing transport links to help patients/ clients find the Staying Well service in Brighton.) |

**Please email completed forms to:**

* **Brighton:** [**stayingwell.brighton@southdown.org**](mailto:stayingwell.brighton@southdown.org)
* **Eastbourne:** [**stayingwell.eastbourne@southdown.org**](mailto:stayingwell.eastbourne@southdown.org)
* **Hastings:** [**stayingwell.hastings@southdown.org**](mailto:stayingwell.hastings@southdown.org)