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**Wellbeing Team – Community Liaison Service**

**Referral Form**

To be completed by the Health Care Professional

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| **Referring Professional** |
| **Date of referral:** |  |
| **Name:** |  |
| **Department:** |  |
| Is the individual aware of and agreeable to this referral? [ ]  Yes [ ] No |
| **Individuals Information** |
| **Name** |  |
| **Address** |  |
| **DOB** |  | **Gender** | [ ]  Female [ ]  Male | [ ]  Other |
| **Contact Number** |  | **Email (If known)** |  |
| **Next of Kin (If known)** |  | **Email (If known)** |  |
| **Discharged** | [ ]  Yes [ ]  No | **Estimated Date****(If known)** |  |
| **Any known Risks?** | [ ]  No Risk | [ ]  Risk to Self-Harm | [ ]  Risk to others |
| **Further details (Optional):** |  |