**Men’s Action Network – Referral Form **

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| **Confidential Information:** |
| Client Name: Client DOB: |
| Client Address: Contact Number: Email: |
| GP/Health Professional Name: |
| GP Address: GP Contact number(s): |
| **Consent has been given to pass on details to MAN (GDPR) Yes 🞏 No 🞏** |
| **Please give a brief outline as to the referral purposes at this stage:** |

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| **COMPREHENSIVE RISK ASSESSMENT**  **If a risk is identified please provide *current & historical* details including triggers and coping strategies.** |
| Suicidal Ideation: |
| Self-Harm Risks: |
| Substance use: (Please be as detailed as possible) |
| Mental Health: (Please be as detailed as possible) |
| Medication: (Please be as detailed as possible) |
| Caring Responsibilities:  Criminal Record: (All offences) |
| Is the Service User a victim of Domestic Abuse: (Please call us on: 02871377777) |
| Who is the Service Users Currently Engaged With: (Statutory and Voluntary Agencies – Names & Contact Details) |

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| **REFERRAL AGENT DETAILS** |
| Name: Signature: |
| Agency: Contact number(s): Email: |

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| ***TO BE COMPLETED BY MAN EVALUATION TEAM:*** |
| Triaged Risk: High **🞏** Medium **🞏** Low **🞏** Allocated to (Initials): Date: |
|  |
| Waiting List ID (EVIDE): |

**FORWARD ALL REFERRAL FORMS TO: ADMIN@MAN-NI.ORG**

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| **Internal Notes:** |