**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:**  |