**Complex Emotional Needs Peer Support Referral Form**

Please email referral to: [Cenps@wclmind.org.uk](mailto:Cenps@wclmind.org.uk) or make an enquiry at 020 8964 1333.

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| --- | --- |
| REFERRER’S DETAILS | |
| Date of referral: |  |
| Organisation: |  |
| Address: |  |
|  |  |
| Postcode: |  |
| Referrer’s name: |  |
| Email: |  |
| Contact number: |  |

|  |  |
| --- | --- |
| INDIVIDUAL’S DETAILS | |
| Surname: |  |
| First Name(s) |  |
| Address: |  |
|  |  |
| Postcode: |  |
| DOB: |  |
| Email: |  |
| Contact number: |  |

|  |  |
| --- | --- |
| Has the person given consent to this referral? | YES/NO |

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| Reason for referral (current difficulties/circumstances) |
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| Mental health support needs, including diagnosis |
|  |

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| --- | --- |
| To help us manage risks: |  |
| History of self-harm in last 12 months | YES/ NO |
| History of violence towards others | YES/ NO |
| Forensic history | YES/ NO |
| History of drug/alcohol misuse | YES/ NO |
| Safeguarding, including bullying | YES/NO |
| Risk assessment available on Systm1 | YES/NO |

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| Any other information that may be relevant: |
|  |

|  |  |
| --- | --- |
| Name: |  |
| Position: |  |
| Signed: |  |
| Date: |  |

We will respond to your referral within 5 working days.