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| --- | --- |
| **OFFICE USE ONLY** | |
| Identification Number |  |
| Date received |  |
| Date to be contacted by  (2 Week Point) |  |



PLEASE RETURN TO:

Sheriff Court Building

Dunnotar Avenue

AB39 2JD

or

eMAIL: info@pillarkincardine.org

**SELF REFERRAL FORM**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PERSONAL DETAILS** | | | | | | | | | |
| NAME: Click or tap here to enter text. | | | | DATE OF BIRTH: Click or tap to enter a date. | | | | | |
| ADDRESS: Click or tap here to enter text. | | | | HOME TELEPHONE: Click or tap here to enter | | | | | |
| MOBILE: Click or tap here to enter text. | | | | | |
| POSTCODE: Click or tap here to enter text. | | | | EMAIL ADDRESS:  Click or tap here to enter text. | | | | | |
| **How would you like us to contact you?** Please tick the most appropriate method**.** | | | | | | | | | |
| **MAIL** | **☐** | **EMAIL** | **☐** | | **HOME TELEPHONE** | | **☐** | **MOBILE** | ☐ |
| if contacting you by telephone can we leave a message? | | | | | | **yes** | **☐** | **No** | ☐ |

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| **REASON FOR REFERRAL?** |
| Click or tap here to enter text. |

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| **HAVE YOU EVER BEEN DIAGNOSED WITH A MENTAL ILLNESS?** If yes, please give details e.g. prescribed medication, hospital admissions etc.... |
| Click or tap here to enter text. |

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| **CRIMINAL CONVICTIONS (Does have any criminal convictions spent or pending?)** | | | |
| **NO** | ☐ | **YES** | **☐** |
| **IF YES PLEASE SPECIFY** Click or tap here to enter text. | | | |

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| **how did you hear about pillar kincardine?** | | | | | |
| Word of Mouth | ☐ | GP | ☐ | Community Psychiatric Nurse (CPN) | ☐ |
| Psychiatrist | ☐ | Occupational Therapist | ☐ | Social Worker | ☐ |
| Citizen’s Advice Bureau | ☐ | Signposting | ☐ | Leaflet | ☐ |
| Website | ☐ | Facebook | ☐ | Twitter | ☐ |
| Other (Please specify) | Click or tap here to enter text. | | | | |

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| --- | --- | --- |
| **DETAILS OF ANY SUPPORT YOU CURRENTLY receive INCLUDING YOUR GP & OTHER AGENCIES** | | |
| **Surgery Name And Address** | **Name Of Your Regular GP** | **Telephone** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Agency Name And Address** | **Contact Name** | **Telephone** |
| Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text. | Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text. | Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text. |

**Thank you for your enquiry and for the information you have provided. Please return the completed referral form to Pillar Kincardine. We plan to review this form and contact you as soon as possible to arrange a meeting.**

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| **OFFICE USE ONLY** | | | |
| **INITIAL CONTACT MADE (DATE)** |  | **ACTION REQUIRED** | |
| **REFERRAL APPOINTMENT**  **ARRANGED FOR (DATE)** |  | **BECOME MEMBER** |  |
| **SERVICE USER ONLY** |  |
| **ACTIONED BY (STAFF NAME):** |  | **Information ONLY** |  |
| **STAFF SIGNATURE:** |  | **NO FURTHER ACTION** |  |
| **DATE:** |  | **SIGNPOSTED TO: (Give details)** |  |