Making Space Psychological Wellbeing Service
Assessment Referral Form

making space
Kind hearted care and support

Date:

PERSONAL DETAILS:

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐

Full Name:

DOB: Age:

Address:

Post Code:

Telephone number:

Can we leave a message? ***(Please tick the appropriate option)***

Yes ☐ *No* ☐

Ethnicity:

Please choose the appropriate option from the drop down list below, or add in your own text

White or White British

Have you ever or are you currently serving in the Armed Forces?
Please tick the appropriate option)

Yes ☐ *No* ☐

Are you currently pregnant or in the post-natal period (up to 2 year following birth of a child, including both parents, step-parents, adoption, fostering or surrogacy)? ***Please tick the appropriate option***

Yes ☐ *No* ☐

GP DETAILS:

Do you consent for us to communicate with your GP?
Please tick the appropriate option)

Yes ☐ *No* ☐

INVOLVEMENT WITH MENTAL HEALTH SERVICES

Are you currently involved with any mental health services?

REASON FOR REFERRAL

Please give brief details of the problem you are currently experiencing (E.g. how long it has lasted for, symptoms you experience and how it is impacting on work, family and social life).