ART MATTERS REFERRAL FORM

For Office Use Only: **Date referral received:**
Date of response to referral:

**** Please ensure all elements of this form are filled out ****

PERSONAL INFORMATION

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐

Gender: Male ☐ Female ☐ Other ☐ Prefer not to say ☐

First Name: _____ Surname: _____

Address: _____

Postcode: _____ Date of Birth: _____

Age: _____ Mobile/Tel: _____

Email: _____

Please tick if you do NOT wish to be contacted by email. ☐

Preferred contact method: _____

Emergency contact name/no: _____

Where did you hear about our service: _____

Do you currently access any other Service: _____

Reason for referral:

What would you like to achieve:

What do you feel we need to know about your wellbeing and physical health?

Supporting Statement / additional information:

PROFESSIONALS INVOLVED

Self-referral: Yes ☐ No ☐

Referrer's Name: _____

Address: _____

_____ Postcode: _____

Mobile/Tel: _____ Email: _____

Is there a current Risk Assessment available? Yes ☐ No ☐ **(If yes, please attach with form)**

MENTAL HEALTH PROFESSIONAL/ORGANISATION

Professional/Organisation Name: _____

Mobile/Tel: _____ Email: _____

GP INFORMATION

Name and Practice: _____

Address: _____

_____ Postcode: _____

Mobile/Tel: _____ Email: _____

Are you a Carer? Yes ☐ No ☐

Are you registered Disabled? Yes ☐ No ☐

Disability (please circle)	Hearing impairment	Autism Spectrum
Physical disability	Dual sensory loss	No impairment
Visual impairment	Learning disability	

ETHNICITY (please circle)	White and Asian	Any other Asian background
English/Welsh/Scottish/	Any other Mixed /	Caribbean
Northern Irish/British	Multiple background	Any other Black / African /
Irish	Indian	Caribbean background
Gypsy or Irish Traveller	Pakistani	Arab
Any other White background	Bangladeshi	Any other background
White and Black Caribbean	Chinese	Prefer not to say
White and Black African	African	

Sexual Orientation (please circle)	Heterosexual/Straight	Gay Woman/Lesbian
	Bisexual	Other Sexual Orientation
	Gay Man	Prefer not to say

Religion (please circle)	Jewish	None
Buddhist	Muslim	Not willing to disclose
Christian	Sikh	
Hindu	Other	

It is important that you understand that on occasions that organisations are obliged to share certain information with other Services e.g. Local Safeguarding of Vulnerable Adults Team; Child Protection Team; other staff; Service's Regulator(s) and other agencies. Should this need arise the Service will make every effort to discuss this with you prior to any information being shared.

Signed Client: _____ **Date:** _____

Signed Referrer: _____ **Date:** _____