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| --- |
| **Your Details**  |
| Date |  |
| Name |  |
| AddressPostcode |  |
| Phone number |  Can we leave a message? Yes No  |
| E-mail address |  |
| Age |  |
| Date of birth |  |
| Gender |  |
| Language spoken |  Interpreter needed |
| Household details | Lives alone Lives with relatives/partner Shared accommodation Has dependent children |
| Details of mental health |  |
| Agencies involved | Are there any other agencies or people helping you? |
| (GP, Psychiatrist, CPN- Community Psychiatric Nurse, Social Worker etc) |  |
| Known risk to self or others |  |
| What would you like Manchester Mind to help you with? |  |
| Any other details |  |
| **Referrer details. Fill in this section if you are completing this form for someone else** |
| Name of Referrer  |  |
| Organisation |  |
| AddressPostcode |  |
| Phone Number |  |
| E-mail address |  |
| **Service requested** |
| **Which CYP service/s would you like to refer to?**  Advice Counselling Peer Support CMHP |

**Please return this form by post to CYP, 709 Stockport Road, Manchester M19 3AG**

**or by e-mail to** **cyp@manchestermind.org**

**Please phone if you require assistance on 0161 769 5732**