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| **CYP Referral Form** | |
| **Your Details** | |
| Date |  |
| Name |  |
| Address  Postcode |  |
| 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 |  |
| Address  Postcode |  |
| Phone Number |  |
| E-mail address |  |
| **Service requested - Which CYP service/s would you like to refer to?** | |
| Peer Support **NB: you must be 18-24 years old to access this service**  Counselling  **NB: you must be 15-25 years old AND a Manchester city council resident to access this service** | |

**Please return this form by e-mail to cyp@manchestermind.org**

**Or by post to CYP, 339 Stretford Rd, Hulme, Manchester M15 4ZY**

**Please phone if you require assistance or signposting on 0161 221 3054**