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| **CYP Referral Form**  |
| **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?** |
|  [ ]  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**