**Edinburgh Self-Harm Support Service**

** Locality Team**

**Thrive Connect Partnership**

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| **REFERRAL FORM** | **Return to:** Penumbra, Locality Team – Self-Harm Support, 5 Leamington Terrace, Edinburgh EH10 4JW Localityteam.edinburgh@penumbra.org.uk | \*Please note, we support people aged 16 years old+ who live in Edinburgh\*Please get in touch with us if you have questions about someone younger or who lives outside of Edinburgh. |
| **Date of Referral:**  |  |
| **PERSONAL DETAILS:** | **REFERRER’S DETAILS:**(if not self-referring):Name:Job Title/Relation to person:Organsiation:Address:Postcode:Telephone No: |
| Title: Ms [ ]  Miss [ ]  Mrs [ ]  Mr [ ]  Other [ ] If Other, please specify: |
| Name: | Preferred Name: |
| Address: |
| Postcode: |
| Can you be contacted at this address? Yes [ ]  No [ ]  |
| Mobile No:Telephone No:Email: |
| Date of Birth/Age: |
| Living Circumstances:Living alone [ ]  Living with someone [ ]  If Living with someone, please specify the circumstance: | Person being referred: Do you have any additional support needs we need to be aware of?Yes [ ]  No [ ] If yes, please provide further details: |
| Gender: Male [ ]  Female [ ]  Non-binary [ ]  Transgender [ ]  Other [ ]  Prefer not to say [ ] If Other, please specify: |
| Preferred Pronouns: She/Her [ ]  He/Him [ ]  They/Them [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Can select more than one if appropriate) |
| Ethnicity:  |
| Sexuality: Heterosexual [ ]  Gay [ ]  Lesbian [ ]  Bisexual [ ]  Other [ ]  Prefer not to say [ ] If Other, please specify: | Have you used this service before?Yes [ ]  No [ ]  |

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| Reason For Referral:  |

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| GP’s details:Name of practice:Name of GP (if applicable):Address:Telephone no: | I would prefer to be contacted by –Phone call [ ] E-mail [ ] Text [ ] Letter [ ]  | I would not like to be contact by – Phone call [ ] E-mail [ ] Text [ ] Letter [ ]  |
| Emergency Contact: | Other Agency Support: |

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| **SELF RISK ASSESSMENT - Please inform us of any relevant risk:****(For referees, please complete Referrer Risk Assessment, found on our website)****History of Violence:****Any convictions pending/court case:****Nature of self-harm:****Previous history of self-harm:****Ongoing suicidality:** |

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| Inform referrer if person did not engage: Yes [ ]  No [ ]  N/A [ ]  |

# This information may be shared with other professionals, to help offer you the best service. This will be discussed with you where we appropriate.

THE INFORMATION WILL BE KEPT ON THE SERVICE ELECTRONIC DATABASE FOR STATISTICS PURPOSES

**Please state exceptions:**

**Do you agree with this?** Yes [ ]  No [ ]

**Person’s Signature:** \_ \_

**Date:** \_\_\_/\_\_\_/\_\_

**Where did you hear about the service:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_