**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](mailto: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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_