FDAMH Third Party Referral Form

Version 1.2 – Jun 2020

Please complete all fields marked *

***Date:**

SECTION A : THE PERSON YOU ARE REFERRING

We will use this information so that we can identify the person and get in touch with them.

Title: (e.g. Ms, Mr)

***First Name:**

***Last Name:**

***Gender:**

○ Male ○ Female ○ Prefers not to say

○ Prefers to self-describe.....

***Requested Service:**

○ Don't Know
○ Family/Carers Support
○ Social Spark
○ Bereaved by Suicide Group
○ Social Prescribing (Central Locality)

Counselling:
○ Ages 19+
○ Ages 16 - 18
○ Fast Track (paying)
○ Other FDAMH Service

For '**Social Spark'** the person must be physically able to move around without help.
For '**Social Prescribing (Central Locality)'** you must be referring from a Central Locality Practice.

Staff Only, Service Note:

***Address**

***Town/City:**

***Postcode:**

***You may write to this address** ○ Yes ○ No ○ Unsure

Email address:

You may send email to this address ○ Yes ○ No ○ Unsure

Mobile Phone:

You may use this phone number to (tick all that apply):

☐ Call ☐ Text ☐ Leave answerphone messages
☐ Leave messages with anyone who answers

Other Phone:

You may use this phone number to (tick all that apply):

☐ Call ☐ Text ☐ Leave answerphone messages
☐ Leave messages with anyone who answers

***Date of Birth:**

GP Surgery

This helps us to monitor our services and if necessary we may use this information to contact the person's GP, with their permission.

***Your reasons for the referral. Include: information relevant to the person's safety or that of our staff / volunteers; details of any mental health diagnosis that you are aware of.**

***Has the person any previous contact with FDAMH?** ○ Yes ○ No ○ Unsure

SECTION B : YOUR (REFERRER) DETAILS

We will use this information so that we can contact you about the referral if required

Title:		(e.g. Ms, Mr)	
***First Name:**		***Last Name:**	
***Organisation:**			
***Job Role/Title:**			
***Address**			
***Town/City:**			
***Postcode:**			
***Email address:**			
Mobile Phone:			
Other Phone:			

Consent to data processing:

By signing below, I confirm that the person being referred:

- understands that they are being referred to FDAMH;
- consents to this referral;
- and consents to the sharing of the information provided.

***Sign to confirm:**	

(Please do not submit a referral if you cannot confirm this information)

To find out more about how FDAMH uses personal information you can visit our website: www.fdamh.org.uk/privacy-policy/ or ask a member of staff for a copy of our Privacy Policy.

Hand in or send this form to: FDAMH, Victoria Centre, 173 Victoria Road, Falkirk, FK2 7AU
Go postage free! Online referral forms are available at www.fdamh.org.uk