Once submitted, a member of the Just ‘B’ team will contact the client to gain consent for the referral and explain the next steps.

**Please mark the box to indicate that the client has given consent for their information to be shared with Just ‘B’ and be contacted using the details provided below** [ ]

Please make the client aware that further information about how we process and store their personal data is available in our privacy notice. Copies of the privacy notice are available on request.

|  |
| --- |
| **Client Details** |
| **Client Name:** |       | **Date of Birth:** |       |
| **Preferred Name:** |       | **Age:** |       |
| **Address/Postcode:** |       | **Tel No:** |       |
| **Email address:** |       | **Language:** |       |
| **Gender:** | Choose an item. | **Ethnic origin:** | Choose an item. |
| **Sexual orientation:** | Choose an item. |  |
| **Communication preferences (please tick all that apply):** | Text | Email | Letter |
|  | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No | [ ]  Yes | [ ]  No |
| **GP Name/Surgery:**  |       |
| **Are there any communication difficulties, disabilities or other conditions the service should be aware of?**  |
|  |  |  | [ ]  Yes | [ ]  No |  |  |  |
| **Please specify:** |       |
| **Referrer Details** |
| **Referrer Name/Job Title:** |       | **Tel No:** |       |
| **Organisation Address/****Postcode:** |       | **Email:** |       |
| **Referral Details** |
| **Date of Referral:**  |       | **Referral for:**  | [ ]  Bereavement [ ]  Pre-Bereavement |
| **Name of the person who is deceased or ill:** |       | **Date of Death or timescales:** |       |
| **Relationship to client:** |       | **Known to service?** | [ ]  Yes | [ ]  No |
| **Cause of Death:** |       |
| **Reasons for Referral:**(Please ensure to provide sufficient information)      |
| **Any suicidal ideation or thoughts of self harming?** | [ ]  Yes [ ]  No |
| **Current Involvement with Community Mental Health Services?** | [ ]  Yes [ ]  No |
| **Contact Details of Care Co-Ordinator** |       |
| **Previous involvement with Community Mental Health Services** | [ ]  Yes [ ]  No |
| **Involvement with other services eg. IDAS/Horizons** | [ ]  Yes [ ]  No |
| **Do you have a mental health diagnosis from a professional?** | [ ]  Yes [ ]  No |
| **If yes please give details.** |       |
| **Currently accessing support through Social Care?** | [ ]  Yes [ ]  No |
| **If yes, please supply the social worker’s details****Social workers name:****Social workers Tel:**  |            |
| Once submitted, a member of the Just ‘B’ team will contact the client to gain consent for the referral and explain the next steps.Please email the completed form to justbadults@justb.org.uk or from and nhs emails address to hnyicb-ny.chcdocuments@nhs.net |
| **FOR JUST ‘B’ OFFICE USE ONLY** |
| **Please read the GDPR statement to the client.** **Can I check you give your consent for us to process and store your personal information? Please mark the box to indicate that the client has given verbal consent** | [ ]  Yes |
| Name of person gaining consent:      Date:      Time:       |
| Preferred method of contact for admin? | [ ]  Letter[ ]  Email[ ]  Text |
| Hear to Help – 01423 856799Samiratians – 116 123 | Numbers given and service explained [ ]  Yes [ ]  No |
| Additional Notes:       |
| Appointment type preference:

|  |
| --- |
| Face-to-face |[ ]
| Video |[ ]
| Telephone |[ ]

 |
| Are there any times at which the client is available? |
|  | AM | PM |
| Monday |[ ] [ ]
| Tuesday |[ ] [ ]
| Wednesday |[ ] [ ]
| Thursday  |[ ] [ ]
| Friday |[ ] [ ]
| Would the client benefit from a late evening appointment? | [ ]  Yes [ ]  No | Please tick [ ]  5pm [ ]  6pm [ ]  7pm |
| Name of worker taking referral: |       |

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