

AGENCY Referral to Pathway2

North East Essex Day Service for people experiencing mental ill health.

Case Number:
(Pathway2 use only)

Date Received:
(Pathway2 use only)

Details	
Referrer Contact Details:	
Telephone:	
Date:	

Client Details			
Name			
Address			
Date of Birth		Postcode	
		Gender	
Preferred contact number			
Alternative contact number			
Is it okay to leave a message on these numbers?	Yes	No	
Any additional contact information?			
Communication issues?			

GP Details	
GP Name	
GP Surgery	
Can we inform GP?	Yes No

ADDITIONAL INFORMATION	PLEASE PROVIDE AS MUCH DETAIL AS POSSIBLE
Ethnic Origin	
Language: (If an Interpreter is required)	
Reason for referral (Attach separate sheet if needed)	
Risk assessment (e.g. risk to self or others, self harm, violent behaviour) (Attach separate sheet if needed)	
Information of other services involved (e.g. CPN etc)	
Information of medication (if relevant)	

CLIENT'S CONSENT OF REFERRAL TO Pathway2

PRINT NAME	
SIGNATURE	

CLIENT'S CONSENT OF SHARING INFORMATION WITH REFERRER (if applicable)

PRINT NAME	
SIGNATURE	

Please return this form to Pathway2, Colchester Mind, St Mary's House, 7 Church Walk, Colchester, Essex CO1 1NS. Alternatively fax referrals to 01206 768866

For additional information about our service contact us on 01206 572504

