

SELF Referral to Pathway2

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

Case Number:
(Pathway2 use only)

Date Received:
(Pathway2 use only)

Have you had contact with mental health services or been diagnosed with a mental illness?

Details: (e.g. CPN, CMHT, Oxford Road)

Client Details

Name			
Address			
			Postcode
Date of Birth		Gender	
Preferred contact number			
Alternative contact number			
In case of emergency contact			
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	
Information of medication (if relevant)	

CLIENT'S CONSENT OF SHARING INFORMATION (if applicable)

PRINT NAME	
SIGNATURE	

CLIENT NOT ELIGIBLE

SIGNPOSTED TO:

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

