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| **WHICH COMMUNITY LIVING WELL SERVICE WOULD YOU LIKE TO REFER YOURSELF TO?** |
| [ ]  | **Employment** | Support to gain or retain paid employment, and improve employability skills through volunteering, training or education.  |
| [ ]  | **Navigators** | Practical support with a range of issues including benefits, debt, housing options, access to health and social care services and support to access specialist advice and information.  |
| [ ]  | **Young Adult Navigator Service**  | A range of support to help 16-25 year olds manage their overall wellbeing including Information, Advice & Guidance, social prescribing, coaching/mentoring, action planning and access to specialised services. Ideal for those with unmet needs, low mood, low motivation, depression, anxiety, CAMHS leavers and care leavers. |
| [ ]  | **Peer Support** | Peer support groups, wellbeing workshops and activities with other people who have had similar experiences to you; organised to help improve your emotional wellbeing and resilience.  |

To refer yourself to [Talking Therapies](file:///%5C%5CMIND-FP01%5CData%5CDocuments%5CMarketing%5CReferral%20Forms%5CTalking%20Therapies) please complete the following online form: <http://bit.ly/2CTNYnk>. To be referred to Community Mental Health Hubs, you must speak to your GP.



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| **DETAILS ABOUT YOU** |
| **Title** (Mr, Miss, Mrs, Ms, Mx etc) |  |
| **First Name:** |  |
| **Last Name:** |  |
| **Date of Birth:** | D | D | / | M | M | / | Y | Y | Y | Y  |
| **What best describes your gender?** | [ ]  Female |
| [ ]  Male |
| [ ]  Prefer not to say |
| [ ]  Prefer to self-describe: |
| **Email address:** |  |
| **Can we email you?:** | [ ]  Yes | [ ]  No |
| **Address:** |  |
|
|
| **POSTCODE:** |  |  |  |  |  |  |  |
| **Can we write to you at your address?:** | [ ]  Yes | [ ]  No |
| **Telephone No:** |  |
| **Can we leave a message on your phone?:** | [ ]  Yes | [ ]  No |
| **Please tell us the best way to contact you** |  |
| **Do you require a translator or counselling in another language?** | [ ]  Yes | [ ]  No |
| **If yes, what language?** |  |
| **GP Practice** |  |
| **GP Name** |  |
| **Please briefly explain your difficulties and if there is a part of the Community Living Well service you are most interested in.** |  |

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| **Referrer Details (if you are completing this form on behalf of someone else, please give *your* details)** |
| **Title** (Mr, Miss, Mrs, Ms, Mx etc) |  |
| **First Name:** |  |
| **Last Name:** |  |
| **Job title:** |  |
| **Service name:** |  |
| **Telephone number:** |  |
| **Email:** |  |

**Please email referral to:** **wlccg.clwwellbeing@nhs.net**

**Referrals can also be posted to: Violet Melchett, 30 Flood Walk, London SW3 5RR**