One to One Project
Counselling • Mentoring • Group Work
Registered charity no. 299052

Nelson House
Bergen Way
North Lynn Industrial Estate
King's Lynn
PE30 2DE
Tel. 01553 770770
www.onetooneproject.com

Health Professional Referral Form **(Please complete all boxes and attach risk assessment. Incomplete forms will be returned.)**

Which service is your client interested in?	Counselling ☐ Mentoring ☐ Group work ☐ Not sure ☐		
Client Details:			
Name:		Date of Birth:	DD / MM / YYYY
Address:		Male ☐ Female ☐ Other ☐	
Post Code:			
How would the client like us to contact them?			
Landline Number:		Please provide all contact details and state client's preferred method of contact.	
Mobile Number:			
Email Address:			
Please tick (a), (b), (c) if you **do not** give permission.	a) leave a message with someone answering their phone ☐ b) leave a message on client's answering machine ☐ c) send reminders via text message to mobile tel. no. ☐		
GP's Details			
GP Name:		Prescribed medication:	
Practice Address:			
Practice Tel No:			
Please list any other services the client is currently receiving (e.g. psychological/psychiatric services)			
Please provide information about any past support from mental health services?			
About your client			
What are the client's current difficulties?			

Summary of Risk Assessment: *Include protective factors and contingency plan as appropriate (Please note that the One to One Project is not a crisis service)*	Date of assessment:
Does the client have difficulties with alcohol and/or non-prescribed drugs? *If yes, please give details:*	Yes ☐ No ☐
What does the client want to achieve with the support of the One to One Project?	
What is the nature of your involvement with this case?	

Please outline any specific needs which we may have to be aware of:
Language?
Cultural?
Access?
Disability?
Other?

Wellbeing and Mental Health Service Referrals only																	
MHCT Scores:																	
1	2	3	4	5	6	7	8	A-J	9	10	11	12	13	A	B	C	D	E

Cluster number:	Date of assessment:
Risk assessment completed? Yes/No	Date of risk assessment:
Key Worker: Telephone:	On CPA? Yes/No
	Discharged form NSFT? Yes/No Date Discharged:

Name and address of Referrer:	**Telephone:** **Email:**
Signed:	**Date:**

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