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**Brent, Wandsworth & Westminster Mind Referral Form**

**Suicide Bereavement Liaison Service North and South West London**

* If you need support in completing this form, ask your GP to help or contact us at sbls@bwwmind.org.uk

**Date of Application/Referral**

|  |  |  |
| --- | --- | --- |
| **Day** | **Month** | **Year** |
|  |  |  |

**Referrer’s Details**

|  |  |  |
| --- | --- | --- |
| **First Name(s)** | **Last Name** | **Position/Role** |
|  |  |  |
| Address (line 1) |  |
| Address (line 2) |  |
| Town |  |
| Postcode |  |
| Phone |  |
| Mobile |  |
| Email |  |

**Applicant/Referral Details**

|  |  |  |
| --- | --- | --- |
| **First Name(s)** | **Last Name** | **AKA (if applicable)** |
|  |  |  |
| Address (line 1) |  |
| Address (line 2) |  |
| Town |  |
| Postcode |  |
| Phone |  |
| Mobile |  |
| Email |  |

**Other information. (Applicant’s date of birth)**

|  |  |
| --- | --- |
| **Date of Birth** | **Age** |
|  |  |

**GP Name and Address, NHS Number of Referred**

|  |  |
| --- | --- |
| **Name of GP** | **Address & Contact Details** |
|  |  |
| **NHS No. (if known)** |  |

**What borough does the Referred/Deceased live in?**

|  |  |  |
| --- | --- | --- |
|  | **Referred** | **Deceased** |
| Brent  |  |  |
| Ealing |  |  |
| Hammersmith & Fulham |  |  |
| Harrow |  |  |
| Hillingdon |  |  |
| Hounslow |  |  |
| Kensington & Chelsea |  |  |
| Westminster |  |  |
| Croydon |  |  |
| Sutton |  |  |
| Merton |  |  |
| Kingston |  |  |
| Richmond |  |  |
| Wandsworth |  |  |
| Other |  |  |

|  |
| --- |
| **What services would help support you?** |
|  |
| **Would you be interested in a group support** | **Please tick** |
| Yes |  |
| No |  |

|  |  |
| --- | --- |
| **Name of Deceased** |  |
| Date of Death |  |
| Relationship to the deceased |  |
| Method |  |

**Accessibility**

|  |  |
| --- | --- |
| **Access** |  |
| Is your/the applicant’s first language English? |  |
| If not English, is translation/interpreting required? |  |
| Do you/does the applicant have a disability? |  |

**Declaration of Applicant**

I confirm that the information I have provided is correct. I also consent to my contact information being used by BWW Mind Bereavement Officers to provide support (I am aware that this information can be deleted at any time if requested).

**Signed:** ……………………………………………..…………………….. **Date:** ……………………………….

Send this form back to: sbls@bwwmind.org.uk

1. **MONITORING INFORMATION**

To promote and ensure equal opportunities in all aspects of our service delivery we gather information on everyone applying or and using our services. This information will be treated with strictest confidence.

Please tick the boxes which apply to you/applicant.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Gender/****Sex** | Male | Female | Are you the same, gender you were assigned at birth.  | Prefer not to say |
| Please Tick |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sexuality** | Bi-sexual | Heterosexual | Gay or Lesbian | Prefer not to say |
| Please Tick |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Ethnicity** | Asian- Bangladeshi | Asian-Indian | Asian-Pakistani | Asian-Other |
| Please Tick |  |  |  |  |
|  | Black African | Black Caribbean | Black British | Black Other |
| Please Tick |  |  |  |  |
|  | Mixed White & Asian | Mixed White &Black African | Mixed White& Black Caribbean | MixedOther |
| Please Tick |  |  |  |  |
|  | White British | White European | White Irish | White Other |
| Please Tick |  |  |  |  |
|  | Arabic | North African | Gipsy/Traveller | Chinese |
| Please Tick |  |  |  |  |
|  | Prefer not to say |  |  |  |
| Please Tick |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Religion** | Christian | Muslim | Jewish | Hindu |
| Please Tick |  |  |  |  |
|  | Sikh | None | Prefer not to say | Other(Please State) |
| Please Tick |  |  |  |  |

**If you have any questions regarding the referral form please contact Brent, Wandsworth, and Westminster Mind Suicide Bereavement Liaison Team at:** sbls@bwwmind.org.uk