Referral Form – Calm Project

This form is for the person requesting a service from GAMH. If you are filling this out on someone's behalf please tell us what this person thinks about their situation.

1. PERSON REQUESTING SERVICE

Date _____

Name Address Post Code Telephone/mobile	Date of Birth Age Gender: Male ☐ Female ☐

Do you care for someone who has a mental health problem? Yes ☐
No ☐

Can we contact you by: letter ☐ phone ☐ mobile ☐ other _____

Do you need an Interpreter? No☐ Yes ☐ Which language?_____

Do you have any additional communication, or other, requirements
(eg: Deaf, Hard of hearing, visual impairment, mobility etc.)?

2. PERSON MAKING REFERRAL

If you are making a referral on this person's behalf have they agreed to this? Yes ☐
No ☐

Contact Person _____

Agency _____

Address _____

Post Code _____

Telephone _____ Mobile _____

3. Are you interested in?

Complementary therapies ☐ Mindfulness ☐

Both ☐

4. If you are interested in receiving complementary therapies, would you prefer to see a therapist:

At home ☐ In another setting ☐

5. Do you have any physical or mental health problems? If so, please provide some information.

6. Are there any areas of safety/risk we should know about? If areas of safety/risk are identified we will contact you for some more information.

7. Is there anything else you think we should know (including your contact with other supports or agencies, need for support with communication or mobility)?

Please return this form to: Calm Project, GAMH, St Andrew's by the Green 33 Turnbull Street Glasgow G1 5PR or calm@gamh.org.uk