|  |  |  |
| --- | --- | --- |
| **Personal Details** | | |
| **Mr  Mrs  Miss  Ms  Other** (check box as appropriate) | | |
| **Full Name:** | | |
| **Date of Birth: Gender:** | | |
| **Address:** | | |
| **Postcode:** | | |
| **Email:** | **Mobile:** | **Landline Tel:** |
| **Ok to leave message on answer machines** | **Yes / No** | **Yes / No** |
| **Do you have any current risks/suicide thoughts/self-harm issues (to self or others)?**  Details: | | |
| **What are the main difficulties/ presenting problems you are experiencing at the moment?**  Details: | | |
| **Completed by: Date:** | | |

**\*Can you email the completed referral form to:** [info@mindmonmouthshire.org.uk](mailto:info@mindmonmouthshire.org.uk)

**Equality and Diversity Monitoring Form**

We won’t give up until everyone experiencing a mental health problem gets support and respect. We want to know a bit more about you, to make sure we understand the needs of all the communities we work with. The information you provide will be entirely anonymous. Thanks for your help.

|  |  |
| --- | --- |
| How old are you (in years)? | |
| …………………… | |
|  | Prefer not to say |

|  |  |
| --- | --- |
| What is your gender? | |
|  | Female |
|  | Male |
|  | Non-binary |
|  | Another / prefer to self-describe …………………… |
|  | Prefer not to say |

|  |  |
| --- | --- |
| Have you ever identified as trans? | |
|  | Yes |
|  | No |
|  | Prefer not to say |

|  |  |
| --- | --- |
| What is your sexual orientation? | |
|  | Bi |
|  | Gay / lesbian |
|  | Heterosexual / straight |
|  | Another / prefer to self-describe …………………… |
|  | Prefer not to say |

|  |  |
| --- | --- |
| What is your ethnic background? | |
|  | Asian |
|  | Black |
|  | Mixed |
|  | White |
|  | Another / prefer to self-describe …………………… |
|  | Prefer not to say |

|  |  |
| --- | --- |
| Which of these categories best represents your experience of mental health problems? (Please tick all that apply) | |
|  | I have personal experience of mental health problems |
|  | I use / have used mental health services |
|  | I am a family member of somebody who has experienced mental health problems |
|  | I am a friend to someone who has experienced mental health problems |
|  | I care or look after someone who has mental health problems |
|  | Another (please specify if you wish) …………………… |
|  | None of the above |
|  | Prefer not to say |

|  |  |
| --- | --- |
| Do you consider yourself to have a long-term health condition or learning difference that has a substantial or long-term impact on your ability to carry out day to day activities? Examples may include a sensory impairment (visual/hearing), physical impairment, epilepsy, mental health problem, Asperger’s syndrome. | |
|  | Yes |
|  | No |
|  | Prefer not to say |