|  |
| --- |
| **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

 **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 |