INT TIME
DATE

IMAGO PROJECT
Referral Form

Client Details

Name…… D.O.B……

Address…… Phone ……
…… Mobile……
BT……..

Gender Female ☐ Male ☐

Next of kin /Contact person

Name…… Phone……..

Address……. Mobile…….
……..
……..

GP Name…….. Telephone……...
Address…….
…….
……
……

Has the patient been assessed using CORE or SFS Yes/ No/Don't Know

Risk Check

Forensic (e.g. criminal record) Yes ☐ No ☐

Violence Yes ☐ No ☐

Alcohol Yes ☐ No ☐

Drugs Yes ☐ No ☐

Details of other agencies/services (CPN, Home Help, Nurse etc)
Telephone.....

Does client live ……..Alone ☐ Married ☐ Separated ☐

Divorced ☐ Widowed ☐ With Partner ☐

Details of relevant medical conditions……..
……..
……..
……

Medication……..
……..

Details of mental health problems……
……
……
……

Duration of symptoms……..

Reason for referral and expectation of service
……
……
……

Has referrer requested other services e.g. CPN or S/W? …….....
…….

NB no referral should be sent without prior client/family discussion
Name of referral agent…….**.....**
(please print)

Designation…….

Address…….. Phone ……
……..
……..
BT……

Signed…….

Date …….

Please return to IMAGO Project Manager
Oasis – Caring in Action
102-108 Castlereagh Street
Belfast BT5 4NJ

Tel 028 90 872277 ext 203/204