MHAP Self-Referral Form

Date of Referral:		Who took referral?	
Your Details			
Name:			
Date of Birth & Age:			
Address:			
Post Code:			
Phone Number:		E-mail:	
Gender:		Pronouns	
Mental Health Diagnosis			
Are you accessing Psychiatry?			
Are you on any compulsory orders (such as STO, CTO)			
Are you subject to Adult Support & Protection?			
Addiction issues and services involved.			
Are you working with other services for learning disability/dementia/autism?			
Where did you hear about us?		Have you worked with us before?	Y/N

How can we help?
We currently have a waiting list in place so please include all relevant information

For Office Use Only	
Who took the referral?	
Category of referral:	M☐ A☐ B☐ T☐ H☐ F☐ E☐ C☐ O☐

Contract Route:	Mental Health ☐ Addictions☐ HMP☐ Carer☐		
Worker & Date Allocated:			
Advocacy Agreement Issued:	Yes / No	Mandate Signed:	Yes / No

Please return completed form to: admin@mhap.org.uk