



For Office Use Only:  
Date Referral Form Received: .....

**REFERRAL FOR MENTAL HEALTH ADVOCACY  
SERVICE F.A.O. GRAHAM HARRIS**

*This services is available for over 65s with mental health problems (diagnosed or undiagnosed) including functional mental illness and dementia and learning disabilities.*

Title: Mr / Mrs / Miss / Ms Surname: \_\_\_\_\_

First name: \_\_\_\_\_ Likes to be called: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_ Tel no: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Any communication needs \_\_\_\_\_

Lives alone/ with \_\_\_\_\_ (delete as appropriate)

Referred by: Name \_\_\_\_\_

Job title: \_\_\_\_\_

Address \_\_\_\_\_

Tel no: \_\_\_\_\_ Fax no: \_\_\_\_\_

Mental health status: \_\_\_\_\_

Reason for referral and summary of client's circumstances:

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.....

Desired outcome from using the service .....

.....  
.....

Have any risks been identified for working with this client.....

.....  
.....

Is the client aware of this referral? YES / NO

Referrer's signature \_\_\_\_\_ Date \_\_\_\_\_

**Please fax completed forms to: 0114 250 2860**

Referrals will be acknowledged within one working day and we aim to undertake an assessment and assign an advocate within one week, provided one is available.