# REFERRAL FORM – LWIEN SERVICE

## LWIEN aims to provide a lifeline to family members or significant others who feel overwhelmed by the daily pressure and mental anguish of caring for a family member/friend/colleague or other, who are suffering from a mental condition.

**The Filled-in referral form has to be sent via email on** **info@antidemalta.org**

# Section A: Details of Referrer and other professionals involved

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Referral:**  | l | **Referring Agency:** |  |
| **Service Unit:** |  | **Profession/ designation:** |  |
|  |
| **Name of Referrer:**  |  | **Warrant No (if applicable):** |  |
| **Direct Telephone/s Nos:**  |  | **E-mail address:**  |  |

**Details of other Professionals involved with the person/ family being referred**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name & Surname** | **Designation** | **Organisation** | **Email** | **Tel. No:** | **Supports which referred person?** |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |

# Section B: Service User Details

**Details of the main person being referred**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:**  |  | **Surname:** |  |
| **ID Number:** |  | **Date of Birth:** |  |
| **Gender:**  |  | **Nationality:** |  |
| **Email address:**  |  | **Mobile/Telephone number:**  |  |
| **Address 1:**  |  | **Address 2 –(locality):**  |  |
| **Language Preferred:**  |  |

**Reason for referral:** ( such as level of distress, for psycho-educational reasons, other )

|  |
| --- |
|   |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Is the service user referred aware of the referral:** | [ ]  | Yes | [ ]  | No | [ ]  | Not Yet |
| **Is the person being referred a caregiver of a mentally ill person:** | [ ]  | Yes | [ ]  | No |   |  |

**If yes, kindly specify the relationship of the caregiver to the person suffering from the mental health condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please also specify what is the mental health condition of the sufferer:**

|  |
| --- |
|   |

**How does the person/s referred think this service can be of help?**

|  |
| --- |
|   |

**What outcomes the person/s would like to achieve through the provision of this service?**

|  |
| --- |
|   |

**In the past and present,  what interventions worked best for the person/s referred?**

|  |
| --- |
|   |

**Other essential information (**Description of the biopsychosocial situation of the person referred If applicable including practitioners/professionals’ comments, support network, practitioners remarks)

|  |
| --- |
|   |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Referrer Date

**Filled-in referral forms are to be forwarded by email to info@antidemalta.org**