**Let’s Connect Social Prescribing Self-Referral Form**

|  |  |
| --- | --- |
| Patient Name:  | Date of Birth:  |
| Patient Address: | NHS Number if known: |
| Patient Telephone Number: Home:Mobile: | Patient Email Address: |

|  |
| --- |
| Surgery Name:  |
| GP’s Name: | Date of self-referral: |
| If this form needs to be emailed by the referrer please email to: tracy.hopkins6@nhs.net |

**Consent**

Details will be held securely in compliance with the Data Protection Act 1998. Verbal consent obtained for personal details to be held by Let’s Connect Social Prescribing

☐Yes ☐ No

**Area of Need**

|  |  |  |
| --- | --- | --- |
| ☐ Making connections | ☐ Housing solutions | ☐ Looking after emotional wellbeing |
| ☐ Managing money and welfare issues | ☐ Managing symptoms | ☐ Healthy lifestyle |
| ☐ Work, volunteering, and activities | ☐ Help to stay living at home |  |

**Eligibility Criteria**

☐ Poor mental wellbeing affected by social circumstance

☐ Frequent attender

☐ Mild to moderate depression or anxiety

☐ Long term physical/mental health condition

☐ Isolated or lonely

Other information you think we need to know