# 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**](mailto:info@antidemalta.org)

# Section A: Details of Referrer and other professionals involved

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| --- | --- | --- | --- | --- | --- | --- |
| **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**

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| --- | --- | --- | --- | --- | --- |
| **Name & Surname** | **Designation** | **Organisation** | **Email** | **Tel. No:** | **Supports which referred person?** |
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# Section B: Service User Details

**Details of the main person being referred**

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| --- | --- | --- | --- |
| **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 )

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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:**

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

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

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

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

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Signature of Referrer Date

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