IMAGO PROJECT
Referral Form (Appendix 1)

CLIENT DETAILS

Name .... **Date of Birth** ....

Address .... **Telephone** ....

....

....

Next of Kin .... **Telephone** ....

Address ....

....

GP's Name ....

Address .... **Telephone** ....

....

....

Has the patient been assessed using CORE, SFS, GHQ 12 or BDI? Yes / No / Don't know

Are you aware of a			
	Forensic risk	☐ Yes	☐ No
	History of violence	☐ Yes	☐ No
	Alcohol abuse	☐ Yes	☐ No
	Drug abuse	☐ Yes	☐ No

Details of other Agencies / Services (CPN, Home Help, Nursing etc)

....

....

Telephone ....

Living Alone	☐	Married	☐	With Partner	☐
Separated	☐	Divorced	☐	Widowed	☐

Details of relevant medical conditions / special needs

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Details of mental health problems (please state any risk factors)

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Reason for application and what is hoped to be achieved

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NB No referral should be sent without prior client / family discussion

Name of referral agent (please print) ………………………………………………………………………..

Signed ………………………………………………………………………..

Designation ………………………………………………………………………..

Telephone ………………………………………………………………………..

Date ………………………………………………………………………..

I, ……………………………………………………..… agree to the information contained in this form being passed on to the Imago Project Manager

Signed: ……………………………………………..

Please return form to

Imago Project Manager
OASIS – Caring in Action
102-108 Castlereagh Street
Belfast BT5 4NJ
Tel 028 90 872277 ext 203 or 4
Fax 028 90 872278
Email Angela.oneill@oasis-ni.org