Washington Mind's primary responsibility is to offer a confidential service for users and enquirers. Washington Mind will only breach confidentiality where there is a duty to share information such as: - Safeguarding (Adult and Child Protection), Risk to self or others, Prejudice, the prevention, detection or prosecution of a serious crime.

Everything below this line must be completed

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Full Name: |  |
| Preferred Name: |  | Date of Birth |  | Gender: |  |
| Full Address (With postcode) |  | Doctor’s Name and Surgery Name: |  |
| Telephone Number: |  | Mobile Number: |  |
| Can we leave voice mails/texts on numbers provided? |  | How do you prefer to be contacted? |  |
| If we can leave voicemails/texts, can we identify that we are contacting you from Washington Mind in the message? |  |
| Next of Kin Name and relationship to you: |  | Next of kin contact number: |  |
| Are you a veteran? |  | Are you an asylum seeker? |  |
| Are you pregnant at the moment, or have you been within the last 12 months? |  | Do you have a criminal record? |  |
| Do you have any physical or learning disabilities? |  | Are you a refugee? |  |
| Should we need to speak to another professional about your care (e.g. your GP), do we have your permission to do so?  |  |
| Just briefly, how would you describe the reason for wanting to access our services? |
| Apart from your Doctor, are there any other professionals involved with your care at the moment? E.g. Health visitor, Social Worker, CPN, etc. |
| From the way you have been feeling recently, do you feel like you are at risk to yourself or anyone else? |