

# **Recovery Navigator Service**

# **(IAP (SWASFT) / Second Step partnership)**

# **Referral form**

You are requesting a referral to the Recovery Navigation service. Initial contact from a Senior Recovery Navigator will be made with the referred individual as soon as possible and within 7 working days upon receipt of this referral form. To proceed with the referral please tick the following boxes to confirm that:

[ ] the referred individual meets the [eligibility criteria](https://swastcpd.co.uk/wp-content/uploads/SWASFT-Recovery-Navigation-Service-Info-for-Referrers-1-1.docx) as specified in the ‘[Information for referrers](https://swastcpd.co.uk/swasft-recovery-navigation-project/)’ document at <https://swastcpd.co.uk/swasft-recovery-navigation-project/>.

[ ] the referred individual has been informed that Recovery Navigation is provided by Second Step, in Partnership with the IAP, and they consent to their details being shared with Second Step to facilitate an initial appointment with the Senior Recovery Navigator.

**Referrer name:** Click or tap here to enter text.

**Email:** Click or tap here to enter text.

**Contact number:** Click or tap here to enter text.

**Potential Client Name:** Click or tap here to enter text.

**Date of Birth:** Click or tap to enter a date.

**Gender:** Male [ ]  Female [ ]  Prefer not to say [ ]  Prefer to self-describe as Click or tap here to enter text.

**Preferred Telephone Number:** Click or tap here to enter text.

**GP Surgery:** Click or tap here to enter text. - Or - Not currently registered with a practice (please tick the box) [ ]

**NHS Number:** Click or tap here to enter text.

**Is it safe/appropriate to leave a message?**  Phone [ ]  Email [ ]  Not appropriate [ ]

Please add further information if needed**:** Click or tap here to enter text.

**Communications needs and preferences:**

Does the client have any specific communication needs? (e.g. another language, large print, etc.)

Click or tap here to enter text.

**Are you aware if they are currently open to Secondary Mental Health Services?** Yes [ ]  No [ ]

**If yes, please provide details:** Click or tap here to enter text.

**Details of preferred support from the Recovery Navigator (please tick all that apply), such as:**

**Mental Health coping strategies** [ ]

**Safety Planning** [ ]

**Access to local community groups or resources** [ ]

**Signposting support** [ ]

**Other, please specify:**

Click or tap here to enter text.

**Have you identified any risks?**Click or tap here to enter text.

**Is there anything else that the Recovery Navigator should know?**

Click or tap here to enter text.

**When this form is complete, please email a copy to:**

* **To:** sshaltd.secondstep.swasftreferrals@nhs.net
* Please includeRecovery Navigation team manager Liam Dixon and Senior Recovery Navigator Caterina Scalesia:
* **cc:** liam.dixon4@nhs.net
* **cc:** caterina.scalesia@nhs.net

**THANK YOU**