

**Referral Form for Health Care Professionals**

Referrals can be made for all women and non-binary people who need support maintaining their mental health and would benefit from spending time in, and contributing towards, a community flower garden. Please note we are a trans-inclusive space.

Please fill out as much detail as possible and return to Kate Evans on [kate@bloomsheffield.com](mailto:kate@bloomsheffield.com). If you have any questions please do not hesitate to contact us.

| Date: |
| --- |

| **Person being referred** | |
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| Full name: | |
| Age and date of birth: | |
| Ethnicity: | |
| Address and postcode: | |
| Phone number: | |
| Email address: | |

| **Caring Status** (Complete as appropriate) |
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| * Has a carer * Is a carer |
| Name and contact details of main carer: |

| **Nature of mental health difficulty, including details of any on-going risk of self-harm or harm to others, effects of medication etc.** |
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| **Nature of any physical health problems that we need to take into consideration.** |
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| **Any other information that may affect the person’s ability to attend Bloom Sheffield’s activities e.g. drug/alcohol use, criminal convictions, language barriers.** |
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| **Referrer details** | |
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| Name of referrer: | |
| Organisation: | |
| Relationship to person being referred: | |
| Email: | Phone number: |