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| **WHICH COMMUNITY LIVING WELL SERVICE WOULD YOU LIKE TO REFER YOURSELF TO?** | | |
|  | **Employment** | Support to gain or retain paid employment, and improve employability skills through volunteering, training or education. |
|  | **Navigators** | Practical support with a range of issues including benefits, debt, housing options, access to health and social care services and support to access specialist advice and information. |
|  | **Peer Support** | A range of group and one-to-one support to improve social, emotional, and practical skills and resilience, by people with lived experience. |
|  | **Self-Care** | Support and activities that help you to take control of your mental, physical and emotional wellbeing. |

To refer yourself to [Talking Therapies](Talking%20Therapies) please complete the following online form: <http://bit.ly/2CTNYnk>. To be referred to a Primary Care Liaison Nurse you must speak to your GP.



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| **DETAILS ABOUT YOU** | | | | | | | | | | | | | | | | | | |
| **First Name:** |  | | | | | | | | | | | | | | | | | |
| **Last Name:** |  | | | | | | | | | | | | | | | | | |
| **Date of Birth:** | D | D | | / | | | M | M | | / | | Y | Y | | Y | | Y |
| **What best describes your gender?** | Female | | | | | | | | | | | | | | | | | |
| Male | | | | | | | | | | | | | | | | | |
| Prefer not to say | | | | | | | | | | | | | | | | | |
| Prefer to self-describe: | | | | | | | | | | | | | | | | | |
| **Email address:** |  | | | | | | | | | | | | | | | | | |
| **Can we email you?:** | Yes | | | | No | | | | | | | | | | | | | |
| **Address:** |  | | | | | | | | | | | | | | | | | |
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| **POSTCODE:** |  | |  | | |  | | |  | |  | | |  | |  | |
| **Can we write to you at your address?:** | Yes | | | | No | | | | | | | | | | | | | |
| **Telephone No:** |  | | | | | | | | | | | | | | | | | |
| **Can we leave a message on your phone?:** | Yes | | | | No | | | | | | | | | | | | | |
| **Please tell us the best way to contact you** |  | | | | | | | | | | | | | | | | | |
| **Do you require a translator or counselling in another language?** | Yes | | | | No | | | | | | | | | | | | | |
| **If yes, what language?** |  | | | | | | | | | | | | | | | | | |
| **GP Practice** |  | | | | | | | | | | | | | | | | | |
| **GP Name** |  | | | | | | | | | | | | | | | | | |
| **Please briefly explain your difficulties and if there is a part of the Community Living Well service you are most interested in. For Self-Care services, please select two services you would like to refer to.** |  | | | | | | | | | | | | | | | | | |

