**‘Mind The Gap’ Self-Referral Form**

* Your first name\*

DOB:

* Your phone number (Mobile or telephone)\* / Emergency contact & number

…………………………………………………………………………..

* Email address\*

…………………………………………………………………………..

****Primary reason for self-referral

Choose an item.

………………………………………………………………………….

* What is the best day to contact you?\*



* What is the best time to contact you?\*



Please state the GP you are registered to?

…………………………………………………………………...........

You consent to us contacting your GP/External support, regarding your well-being? (please tick box below, if so):

[ ]

Are you under the care of a CMHT? (If yes, please state):

…………………………………………………………………...........

Known Medical Conditions (Please let us know about any known medical conditions which may affect your ability to exercise. Failure to provide this information, may slow down the referral process):

Choose an item.

………………………………………………………………………...

Medication (Please provide medication details/reason for medication taken by yourself and any potential side effects, which the ‘deliverer’ should be aware of when considering your engagement in the programme)

The information provided on this form will be shared with your appropriate ‘deliverer’ and data will be used to help design a safe and effective (data collection and analysis stated in SOP QS document) provision. Please sign below and return form to **kmccarthy@cardiffmet.ac.uk** if you are happy for this information to be shared.

Signed: ………………………………………………….......

Date: ………………………………………………………….