

**Condition Management Programme (CMP)**

**CMP 1 Referral Form**

1. **Client**

**I wish to be referred to the Condition Management Programme (CMP) provided by my local Healthcare Trust. I understand that Health and Work Support Branch staff (H&WSB) and Health Service Providers engaged in the management and delivery of the CMP and Jobs & Benefit Office / Job Centre staff (where applicable) will exchange the information below relevant to my involvement in the programme.**

**If CMP staff need to contact your GP and /or access health service record systems as appropriate they will contact you directly to arrange for your consent.**

 **(Privacy Notice available at the following web link)**

[**www.communities-ni.gov.uk/sites/default/files/publications/communities/dfc-gdpr-privacy-notice-wig.pdf**](http://www.communities-ni.gov.uk/sites/default/files/publications/communities/dfc-gdpr-privacy-notice-wig.pdf)

**If client present** Client’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Click here to enter a date.

**If not present / telephone referral record kept of conversation regarding the above** [ ]  please tick

Referrer’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date & Time: Click here to enter a date.

**OR**

CMP staff signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date & Time: Click here to enter a date.

1. **CMP Trust:** Choose an item. x

Referrer Source: Choose an item.

Referrer name and contact details (telephone / mobile) 

Referrer E-mail details 

Organization: 

1. **Client Details**

Title: Mr [ ] Mrs [ ] Miss [ ] Ms[ ] Other (please specify) 

Surname  ­­­­­­­­­­­First name 

NI Number  Date of birth Click here to enter a date.

Address 

Post Code  Home no. 

Mobile  Email 

Interpreter Required Yes[ ]  No[ ]  Language 

1. **Complete this section *if On Benefit***

Client currently in receipt of: Choose an item.

Time since last worked Choose an item.

Does client still have open contract of employment? Yes[ ]  No [ ]

Occupational sector Choose an item.

Was in work: Full time [ ]  Part time [ ]  Hrs worked 

1. **Complete this section *if currently in Employment***

Full time [ ]  Part time [ ]  Current Hours Worked 

Attending work [ ]  Off sick [ ] Choose an item.

Name /address of employer 

Occupational Sector: Choose an item. Job Role 

1. **Disabilities / Health Conditions**

The client has reported their health conditions / disabilities as:





Does the client have any special requirements for CMP assessment e.g. ground floor room, large chair, If so, please specify 

**ON COMPLETION PLEASE FORWARD TO RELEVANT TRUST VIA SFTP IF FROM J&BO/JC, or to H&WSB VIA SFTP IF FROM ATW OR WORKABLE (WNI). FOR ALL OTHERS PLEASE FORWARD TO THE RELEVANT TRUST VIA SECURE EMAIL ADDRESS, PASSWORD PROTECTED BELOW, OR IF BY POST PLEASE PHONE FOR POSTAL ADDRESS.**

**Belfast** **cmpinfo@belfasttrust.hscni.net** **Tel: 02890638801**

**Northern** **ConditionManagement.Programme@northerntrust.hscni.net** **Tel: 02825635250**

**South Eastern** **ConditionManagement.Programme@setrust.hscni.net** **Tel: 02892605494**

**Southern** **ConditionManagement.Programme@southerntrust.hscni.net** **Tel: 02837517173**

**Western** **Condition.management@westerntrust.hscni.net** **Tel: 02871376911**

For Official Use Only – CMP Staff

Date CMP1 received Click here to enter a date.

Database updated on Click here to enter a date.

Passed for screening on Click here to enter a date.