**Referral Form**

Please return this form to [vitahealthgroup.refer.bnssg@nhs.net](mailto:vitahealthgroup.refer.bnssg@nhs.net)

|  |  |
| --- | --- |
| **Date received:** | **IAPTus Number (office use only):** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Details** | | | | | | | | | | | | | |
| Title: | | | | | | | Date Sent: | | | | | | |
| First Name(s): | | | | | | | NHS Number: | | | | | | |
| Surname: | | | | | | | GP Full Name: | | | | | | |
| Address: | | | | | | | Surgery Address: | | | | | | |
| Telephone Number:  Can we leave a message? Yes/No | | | | | | | Surgery phone number | | | | | | |
|  | | | | | | |
| Date of Birth: | | | | | | | Ethnicity: | | | | | | |
| Gender: M / F | | | | | | | Relationship Status: | | | | | | |
| Please detail any Language, Religious or other requirements: (e.g. is an interpreter required , learning difficulties etc.) | | | | | | | | | | | | | |
| Disabilities: | | | | | | | | | | | | | |
| Visual |  | Speech | |  | Mobility | |  | Hearing | |  | Learning Disabilities | |  |
| Please give details: | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Consent to contact GP? | | | Yes | | |  | | | No | | |  | |
| We will always contact your GP if we need to keep you or others safe. | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Contact Information** | | | | | | |
| Mobile:  Can we leave a message Yes/ No | Work :  Can we leave a message Yes/ No: | | | | | |
| Home:  Can we leave a message Yes/ No | Preferred contact | | | | | |
| Home |  | Mobile |  | Work |  |
| Preferred Contact Times: | | | | | | |

**Vita Health Group provide a short-term psychological therapies service only, suitable for mild to moderate mental health or behavioural difficulties, or severe stable presentations.** To enable us to process this referral, we require the following information to be provided in full.

**Please Note**: If signs of psychosis or higher risk (suicidal intent, plan) are present please refer to Primary Care Liaison Service.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of referrer: |  | Organisation: |  |
| Telephone: |  | Email: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Reason For Referral** | | | |
| **Primary problem/s** | | | |
| Depression |  | Generalised Anxiety Disorder |  |
| Social Anxiety Disorder |  | Panic Disorder |  |
| Agoraphobia |  | Obsessive-Compulsive Disorder |  |
| Specific (isolated) Phobia |  | Post-Traumatic Stress Disorder |  |
| Health Anxiety |  | Body Dysmorphic Disorder |  |
| Long-Term Conditions and Medically Unexplained Symptoms in the context of depression and anxiety disorders (e.g diabetes, COPD, chronic pain, CHD, CFS, IBS, Fibromyalgia, stroke). |  | Somatoform Disorders |  |

|  |
| --- |
| **Any diagnoses over client history** (we require details including date/who by): |
|  |

|  |
| --- |
| **Additional Relevant Referral Information**  (We require details including medication prescribed/duration; current alcohol / drug usage (quantities/frequency)) |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Previous Contact With Mental Health Services including Secondary Care** (We require details including, dates/duration/which service/reason/treatment recommendations/treatment received) | | | | |
| Previous Contact with Psychological Therapist? | Yes |  | No |  |
| If Yes, Please Give Details (including, intervention offered/dates/engagement) | | | | |
| Is there any ongoing contact with Secondary Mental Health Services? | Yes |  | No |  |
| If Yes, Please Give Details | | | | |

|  |
| --- |
| **Risk Information**  We require information about **past/current risk** and **risk management plans** : |
| **To self** (self harm / suicide) |
| **Current:** |
| **Historical:** |
| **To others** (including safeguarding information / offending history) |
| **Current:** |
| **Historical:** |
| **From others** |
| **Current:** |
| **Historical:** |
| **Safety Plan or Contingency Management Plan:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Employment** | | | | |
| Employment difficulties? | Yes |  | No |  |
| Please provide further information: | | | | |

|  |
| --- |
| **Long Term Conditions identified** |
| Please provide details (e.g. chronic fatigue, pain, cancer, IBS, cardiology, etc): |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please Indicate if Patient Falls within These Groups:** | | | |
| Long Covid |  | Medically Unexplained Symptoms |  |
| Offender |  | Perinatal |  |
| Veterans |  |  |  |