**Referral Form**

Please return this form to vitahealthgroup.refer.bnssg@nhs.net

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| **Date received:** | **IAPTus Number (office use only):** |
| **Is this patient a Winter Pressures Referral?** | **Yes/No** |

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| **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 |
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| 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: |
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| Consent to contact GP?  | Yes |  | No |  |
| We will always contact your GP if we need to keep you or others safe. |

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| **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.

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

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| **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 |  |

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| **Any diagnoses over client history** (we require details including date/who by): |
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| **Additional Relevant Referral Information** (We require details including medication prescribed/duration; current alcohol / drug usage (quantities/frequency)) |
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| **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 |

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| **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:** |

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

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

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