Referral Form

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

**‘NHS Talking Therapies for anxiety and depression’ provide a short-term psychological therapy service for common mental health problems only.** We do not treat severe mental health problems (e.g. psychosis, complex emotion needs including personality disorder, complex PTSD, eating disorders and other complex conditions).

To enable us to process this referral, we require the form below to be completed in full.

**Consent:** By submitting this form you are confirming that the client has consented to a professional referral to our service.

|  |  |
| --- | --- |
| **Client Details** | |
| NHS Number: |  |
| Title: |  |
| First Name(s): |  |
| Surname: |  |
| Address: | POST CODE: |
| Email: |  |
| Telephone Numbers: |  |
| Home: |  |
| Can we leave a message? Y/N |  |
| Mobile: |  |
| Can we leave a message? Y/N |  |
| Date of Birth: |  |
| Gender: |  |
| Ethnicity: |  |
| Sexuality: |  |
| Disability: |  |
| Religious group: |  |
| Access needs (please detail any language, religious or other requirements, e.g. is an interpreter required, learning difficulties, cultural requirements  etc.) |  |

|  |  |
| --- | --- |
| **GP Details** | |
| GP Surgery Name and Address: |  |
| GP Surgery phone number |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Details (only complete if referrer is NOT the GP)** | | | |
| Name of referrer: |  | Organisation: |  |
| Telephone: |  | Email: |  |

**Reason For Referral**

Include probable common mental health diagnosis (e.g. Depression, GAD, OCD, Phobia, Panic Disorder, PTSD, Body Dysmorphia, Illness Anxiety)

**Drug/Alcohol Use**

Current and historical dependency on substances

**Risk Information**

We require information about **past/current suicide and self-harm risk,** any **risk to others**

and **risk management plans**:

**Long Term Conditions**

Details of any long-term conditions the client experiences

|  |  |  |  |
| --- | --- | --- | --- |
| **Please Indicate if Client Falls within These Groups:** | | | |
| Perinatal period (pregnancy & first 2 years after childbirth) |  | Veteran |  |

**Please attach relevant assessment documentation/risk management plans wherever possible as these will greatly support our decision making.**