East London NHS
NHS Foundation Trust

Institute of Psychotrauma
East London NHS Foundation Trust
61 St Bartholomew Close
London EC1A 7BE
Tel/Fax: 020 7601 7019

REFERRAL FORM

Surname:	**First Name:**	**Gender: M/F**
D. o. B:	**Ethnicity:**	**Religion:**
Address:		
Contact Numbers: (Home)		**(Mobile)**
Language Support needed?	**Details:**	
Index Trauma:		
Referrer Details: **Name:**	**GP Details** **Name:**	
Service:	**Practice:**	
Address	**Address:**	
Tel/Fax:	**Tel/Fax:**	
Next of Kin/Emergency Contact: **Contact Details:**	**Relation to Client:**	
Consultant Psychiatrist:		
Current Medication:		
Current Physical Health/Disability Status:		

Has this Patient been referred to the Institute before? **Yes No**

Please submit reason for referral and attach any assessments including risk and full needs as well as most recent correspondence with the GP

Signed **Date**

Office use only

Appropriate? YES NO:	Allocated Clinician:	
Database no.:	1st Appt Date:	