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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **BASIC DEMOGRAPHICS** (PLEASE CHECK DETAILS ARE CORRECT WITH PATIENT) | | | | | | | | | | | | | | | | | | |
| **NHS Number** | |  | | | | | | | | | | | **Date of Birth / Age** | | | |  | |
| **Last name** | |  | | | | **First name** | | | | | |  | | | | | | |
| **Gender** | | Male Female | | | | **Pregnant** –  Yes No.  N/A  Expected Date of Delivery – | | | | | | | | | | | | |
| **Current address include full Postcode** | |  | | | | | | | | | | | | | | | | |
| **Phone number** | |  | | | | **Email address** | | | | | |  | | | | | | |
| **Mobile Number** | |  | | | | | | | | | | | | | | | | |
| **GP Name** | |  | | | | **GP Practice/Surgery Address** | | | | | | | | | | | | |
| **Marital Status**  (please tick one) | | **□**Married/Civil Partner **□**Single **□**Separated **□**Divorced/Civil partnership has dissolved **□** Widow /Surviving Civil Partner **□** Not Disclosed | | | | | | | | | | | | | | | | |
| **Ethnicity** | |  | | | | **Religion** | | | | | |  | | | | | | |
| **Nationality** | |  | | | | **Disability** | | | | | |  | | | | | | |
| **Language** | |  | | | | **Interpreter Required?** | | | | | | Yes  No | | | | | | |
| **Occupation** | |  | | | | | | | | | | | **No. of hours worked** | | | | | |
| **Housing /Accommodation Status** | | | | | | | | | |  | | | |  | | | |  |
| **Does the service User have a Carer?** | | Yes No | |  | | | | **Carer Name & Contact Details** | | | | | | | | | | |
| 1. **FAMILY/HOUSEHOLD COMPOSITION** | | | | | | | | | | | | | | | | | | |
| **First name, Surname** | **Date of Birth/Age/EDD** | | | | **Gender** | | **Under 18**  **Yes/No** | | | | **Relationship** | | | | **Location**  **(Accommodation and School**  **for the children)** | | | |
|  |  | | | |  | |  | | | |  | | | |  | | | |
| 1. **REFERRAL INFORMATION** | | | | | | | | | | | | | | | | | | |
| **Referrer Name:** | | |  | | | | | | **Phone Number/**  **Fax No:** | | | | | | |  | | |
| **Referrer address:** | | |  | | | | | | **Postcode:** | | | | | | |  | | |
| **Referral Date:** | | |  | | | | | | **Referral Time:** | | | | | | |  | | |
| **Referral History:** | | | **Re-Referral** If yes when was the last contact with Mental health services | | | | | | | | | | | | | **New Referral** | | |
| **Is Patient aware of Referral?** | | | **Yes**  **No**  **If No please specify reason:** | | | | | | **Details taken by** | | | | | | | (sign and print) | | |

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| 1. **REASON FOR REFERRAL.** |
| (Please include patient’s current mental state and risks. Please include medication list, recent consultation at GP surgery.) |
| (Please include information on any other agencies presently working with client e.g. Probation services, Children services / Team, Midwife/Health Visitor, Adult Social Care. Please provide name of case worker, contact telephone number and e-mail address) |

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| 1. **CHRONOLOGICAL MEDICAL HISTORY** |
| If patient has previous mental health history please give details including previous letters (it is important to establish history and level of risk) |