|  |
| --- |
| 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) |

|  |
| --- |
| 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) |

|  |
| --- |
| 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) |