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| **Referral Form**  |  | **Date of Referral** |  |
| **Patient Details** |  |  |  |
| **Client Name** |  |
| **Any Other Names/Alias** |  |
| **Date of Birth:** |  |
| **Gender:** |  |
| **Address:**  |  |  |
| **Is the address:** | Permanent [ ]  Temporary [ ]  |
| **Telephone Number:** |  |
| **Email Address:** |  |
| **Has the patient consented to the referral?** | Yes [ ]  No [ ]  If no please state why: |
| **Do you consent to us contacting you by:** | **Phone** | Yes [ ]   | No [ ]  |
| If no please state why |  |
| **Letter to the above address** | Yes [ ]   | No [ ]  |
| If no please state why and confirm alternative address if appropriate |  |
| **Text Message?**  | Yes [ ]   | No [ ]  |
| **Voicemail Message?** | Yes [ ]   | No [ ]  |
| **Email**?  | Yes [ ]   | No [ ]  |
| **NHS number:** |  | **Relationship Status:** |  |
| **Ethnicity:** |  | **Nationality:** |  |
| **Religion:** |  | **Employment Status:** |  |
| **Communication Difficulties?**  | Yes [ ]  No [ ]  If yes please specify: |
| **How did you hear about TILS?** |  |

**GP Details**

|  |  |
| --- | --- |
| **GP Name:** |  |
| **Practice Name:** |  |
| **Practice Address:** |  |
| **Contact Number:** |  |
| **Email Address:** |  |

**Referrer Details (if not self referral)**

|  |  |
| --- | --- |
| **Referrer Name:** |  |
| **Position/Role:** |  |
| **Address:** |  |
| **Contact Number:** |  |
| **Email Address:** |  |

**Military Service Details**

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| --- | --- |
| **Branch of Armed Forces:** | Army [ ]  Royal Navy [ ]  RAF [ ]  Royal Marine [ ]   |
| **Regular or Reserve:**  | Regular [ ]  Reserve [ ]   |
| **Service Number:**  |  |
| **National Insurance Number:** |  |
| **Service Dates:** |

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| --- | --- |
| **Year Enlisted: \_\_\_\_\_\_\_\_\_\_** | **Year Discharged: \_\_\_\_\_\_\_\_\_** |

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| **Are you Currently Enlisted?**  | Yes [ ]  No [ ]   | If yes, do you have a discharge date?  | Yes [ ]  No [ ]   |
| **Rank on discharge:** |  |
| **Were you Deployed Operationally?**  |  Yes [ ]  No [ ]   | If yes, please state each tour with approximate years: |
|  |

**Next of Kin**

|  |  |
| --- | --- |
| **Relationship to Client:** (e.g. partner, family member, friend, neighbour etc.) |  |
| **Is it OK for them to be contacted?**  | Yes [ ]  No [ ]   |
| **Address:** |  |
| **Contact Number:** |  |
| **Email Address:** |  |

**Carer**

|  |  |
| --- | --- |
| **Do you have a carer/family member/friend that supports you day-to-day?** | Yes [ ]  No [ ]   |
| **Does this carer require information and advice from us?**  | Yes [ ]  No [ ]  Don’t Know [ ]   |
| **Name of carer or person cared for:** |  |
| **Relationship to Client:** |  |
| **Address:** |  |
| **Contact Number:** |  |
| **Email Address:** |  |

**Reason for Referral**

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| **If possible please include; the nature of the problem; triggers; time of onset and what you would like help with.**   |
|  |
| **Have you had previous mental health problems and/or contact with mental health services?** Yes [ ]  No [ ]  If yes, please give details: |
|  |
| **Do you feel there are significant risk issues to yourself or others?** Yes [ ]  No [ ]  If yes, please give details:**Our service does not provide emergency care. In the event of an emergency you are advised to contact your GP, local crisis number, attend your nearest A&E Department or dial 999.** |
|  |
| **Are you using alcohol?Are you using illicit substances?Do you smoke?** | Yes [ ]  Yes [ ]  Yes [ ]   | No [ ] No [ ] No [ ]  | If yes, please give basic details regarding substance used, amount and frequency: |
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|  |  |
| --- | --- |
| **Current prescribed medication:** |  |
| **Do you have any children? Do they live with you?** | Yes [ ]  Yes [ ]   | No [ ] No [ ]  |
| **Do you have any physical health problems?** | Yes [ ]   | No [ ]  | If yes, please provide details: |
|  |
| **Do you consider yourself to have a disability?**  | Yes [ ]   | No [ ]  | If yes, please provide details: |
|  |
| **Do you have any accessibility needs (e.g. can’t climb stairs, use of crutches/ wheelchair etc.)?** | Yes [ ]   | No [ ]  | If yes, please provide details: |
|  |
| **Any other information:** |
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| **Are there other services currently involved in your care (e.g. Primary Care NHS, Royal British Legion, Combat Stress, Walking with the Wounded)?**  | Yes [ ]   | No [ ]  | If yes, please provide details: |
| **Service:**  |  | **Name of Professional:**  |  | **Contact:** |  |
| **Service:**  |  | **Name of Professional:**  |  | **Contact:** |  |
| **Service:**  |  | **Name of Professional:**  |  | **Contact:** |  |