****





|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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**

|  |  |  |  |
| --- | --- | --- | --- |
| **Branch of Armed Forces:** | Army  Royal Navy  RAF  Royal Marine | | |
| **Regular or Reserve:** | Regular  Reserve | | |
| **Service Number:** |  | | |
| **National Insurance Number:** |  | | |
| **Service Dates:** | |  |  | | --- | --- | | **Year Enlisted: \_\_\_\_\_\_\_\_\_\_** | **Year Discharged: \_\_\_\_\_\_\_\_\_** | | | |
| **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**

|  |  |  |  |
| --- | --- | --- | --- |
| **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: | |
|  | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **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:** | | | | |
|  | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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:** |  |