**Client Led Referral Form**

**PLEASE NOTE THIS IS NOT A SELF REFERRAL FORM – we hope this form can be completed collaboratively by client and referrer.**

Gaps in information may result in delay in processing referral, it is particularly important that the referrer includes an up-to-date risk history.

**Single Point of Access**

**Centre for Specialist Psychological Therapies**

**PART 1**

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| **Date:**  |

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| **Patient details:****Name:****Preferred name:****Pronouns:** |
| **Address:** |
| **Telephone No:** |
| **Email address:**  |
| **Date of Birth: NHS No** if known:  |
| **Ethnicity:** **Next of Kin:**   |
| **GP Details and Address:** |
| **Care Co-Ordinator/ Other services involved (if any):**  | **Contact Telephone Number:** |

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| **Psychological Therapy:****Within the Centre, we offer a range of Psychological Therapies. If you require further information about these, please contact** cspt@cntw.nhs.uk. If you know what therapy, you would like to engage with from the options below please tick the relevant box. **Please select which therapy\* you are requesting:**CAT (Cognitive Analytic Therapy)CBT (Cognitive Behavioural Therapy)Psychotherapy IPTEMDR\*We will take your request into consideration at Single Point of Access.  |
| **Current difficulties:**Please could you tell us what you are struggling with? It can be helpful to know, when this started and how it affects you? *Do you need any support or adjustments that would help you get the most out of therapy? (e.g., physical health, mobility, or visual impairments, how do you get to your appointments? e.g. are you able to drive or do you use public transport)*  |
| **What are you hoping for from any treatment offered:**“I would like help with…”  |
| **Previous psychological therapies:**Can you tell us about any previous therapy:

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| --- | --- | --- | --- |
| **Therapy/Target problem** | **How long was it for?** | **When did it end?** | **Was it helpful?** **Y or N** |
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| **Current ways of managing:**Please can you describe any recent or past events, which you or others consider risky and/or dangerous?Do you use alcohol or drugs to help you manage your current difficulties? Have you ever done so in the past? If so, when? |
| **Childhood & Personal History:**Is there anything from your own childhood personal experience that you think is influencing your current difficulties or important to share?Yes No **Can you say more?**  |
| **Medication:**Please include any relevant medication which we need to be aware of in relation to managing a mental health or physical health condition?  |
| **Do you have any involvement with other services in addition to health?** This may include court proceedings, probation services, third sector organisations, police, children’s/adult services etc. |
| **Social situation:**Can you please tell us a little about who you would consider to be supportive in your life and any significant relationships? |
| **Is there anything else you feel it would be important for us know?****Do you give permission for us to contact previous services (including Talking Therapies) to support the triage process? YES**  **NO****Do you give us permission to contact you by phone to discuss your referral to our service further if necessary? YES**  **NO****If yes on what number ……………………….****Are there any times you wish us to avoid?**  |
| **Part 2****The following information needs to be completed by the person referring you to the service.** **Name:****Service:** **Contact telephone no:** **Email address:****Role and relationship to person being referred to the service:**  |
| **Additional information****Please can you include any relevant additional information – this may include relevant risk history/previous psychiatric admissions.** **Please return completed forms to:** referralCSPT@cntw.nhs.uk Contact telephone no: 0191 287 6100 |

We would welcome any feedback regarding how you found filling in this form or your experience of being referred to our service. CSPTinvolvement@cntw.nhs.uk