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| Professionals Referral Form |
| **Client/ patient contact information** |
| Name: |  | Date of Birth: | DD / MM / YYYY |
| Address: |  | Male  | □ |
| Female | □ |
| Postcode: |  | NHS Number: |  |
| Landline Number: |  | We will try to contact the client by telephone unless otherwise advised. If possible, please provide a mobile number in addition to a landline.  |
| Mobile Number: |  |
| Email Address: |  |
| Please tick (a), (b), (c), (d) if consent has been given  | 1. leave a message with someone answering the phone
 | □ |
| 1. leave a message on the answering machine
 | □  |
| 1. send reminders via text message to their mobile
 | □ |
| 1. send a message via email
 | □ |
| **GP Details** |  |
| GP Name: |  | To find the GP address go to <http://www.nhs.uk/service-search> |
| Practice Address: |  |
| Postcode: |  |
| Practice Tel No: |  |
| **Referrers details** |  |
| Referrers name: |  | Has the referral been discussed with and agreed by the client/patient?\*  ☐ Yes  ☐ No*\* Please note, we require consent from the client to process the referral* |
| Agency Name: |  |
| Address: |  |
| Post Code: |  |
| Telephone number: |  |
| Fax number: |  |
| I confirm the person I am referring gives permission for you to discuss details of their referral with me?\* | ☐ Yes, client gives permission to discuss details☐ No, client does not give permission to discuss details |

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| **Presenting Problem**  |
| Please provide a brief summary of the client’s problem |  |
| Are they experiencing any issues related to the below. Please tick where appropriate. |
| Domestic abuse | □ |
| Housing | □ |
| Isolation | □ |
| Work-related | □ |

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| **Additional information**  |
| What is their marital status? |  |
| What is their ethnic origin? |  |
| What is their religion? |  |
| Is English their first language? | Yes  | □  | *If no, please give details.* |
| No  | □  |
| Do they have any problems speaking, reading or writing English? | Yes  | □  | *If yes, please give details.* |
| No  | □  |
| Do they have any disabilities we should be aware of? | Yes | □ | *If yes, please give details.* |
| No | □ |
| Do they have any long term health conditions?  | Yes  | □  | *If yes, please give details; e.g. visual, speech, hearing, mobility*  |
| No  | □  |
| Have they served in the armed forces? | Yes  | □  | *If yes, please give details.* |
| No  | □  |
| Is the client or their partner currently pregnant; or had a baby in the last 12 months? | Yes  | □ | *If yes, please give details.* |
| No | □ |

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| **Return this form to:** |  |
| By Email | stockportpws@selfhelpservices.org.uk / shserv.stockport@nhs.net  |
| By Post | The Stockport Psychological Wellbeing Service, “The Studios”, Brookfield House, 193-195 Wellington Road South, Stockport. SK2 6NG |
| By Telephone | 0161 480 2020 |
| By Fax | 0161 667 4190 |