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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](mailto:stockportpws@selfhelpservices.org.uk) / [shserv.stockport@nhs.net](mailto: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 |