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| **Outpatient clinic****E: therapyclinics@stah.org** **T:01604 616050**  |

**Outpatient Clinic Referral Form**

1. **Service User Details**

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| **Name:** |  |
| **Date of birth:** |  |
| **Age:** |  |
| **Mobile number:** |  |
| **Email address:** |  |
| **Address:** |  |
| **NHS Number:** |  |
| **GP Name & Address:** |  |
| **GP Phone number:** |  |
| **Next of Kin:** |  |
| **Relationship to you:**  |  |
| **In instances where sessions are booked and funded by my next of kin, I consent to them being contacted about:** | **Session booking Yes 🗆 No 🗆****Session rescheduling Yes 🗆 No 🗆****Payment reminders Yes 🗆 No 🗆**  |
| **Next of kin address:** |  |
| **Next of kin mobile number:** |  |

1. **Initial Screening Assessment**

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| **Please explain your reason(s) for seeking a psychiatric or psychological assessment:** |  |
| **Do you have any past mental health issues? (including any specialist input, therapy and /or medications etc)** |  |
| **Do you have any medical conditions? (Please list)** |  |
| **Please list your current medications and any allergies to medications:** |  |
| **Do you have any family history of mental health issues? (Please list)** |  |
| **Have you engaged in any harmful behaviors, such as drinking excessively, self-harm, substance misuse? (Please list)****If so when was the most recent incident? And what was the nature of the episode?** |  |
| **Have you either historically or currently had any incidents or concerns about harming others or being a danger to others? (Please list)****If so when was the most recent incident? And what was the nature of the episode?** |  |
| **Are you currently receiving any support for your mental health (e.g., medication, therapy, support groups)?** |  |
| **Are you currently involved in, or do you intend to undertake, any legal proceedings / litigation relating to your mental health?** |  |
| **What would you like to achieve from this consultation?** |  |
| **Please write any additional information that may be helpful prior to being seen:** |  |
| **Are you happy to be seen remotely i.e. via telephone or Microsoft Teams?** | **Yes 🗆****No 🗆** |

1. **Initial Relapse Management Plan**

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| **Please list any triggers or early warning signs that indicate a decline in your mental health (e.g., increased anxiety, trouble sleeping, withdrawal from social activities):** |  |
| **What strategies or techniques do you currently use to manage your mental health?** **(e.g. deep breathing, exercise, talking to a friend, strategies gained from other therapeutic involvement):** |  |
| **Who are the key people you can rely on for support during difficult times? (family, friends, professionals):** | Name: Relationship: Name: Relationship: Name: Relationship: |
| **Please provide an emergency contact (or indicate next of kin)** (**family members, trusted friends, doctors):** | Name:Relationship:Phone Number: |
| **If you experience a mental health crisis, what steps do you plan to take?** **(e.g. contact your next of kin, go to A&E, call a helpline):** |  |

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| **All documents will be emailed to you unless you request a paper copy. Please tick if you are happy for us to contact you in the following ways:** **Email** [ ]  **Phone** [ ]  **Letter** [ ]  **Text** [ ] **All emailed documents will be encrypted using Egress** |

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| **I consent to:**[ ]  **Correspondence being sent to my GP**[ ]  **Documents being sent to my home address**[ ]  **Being contacted by email**[ ]  **Being contacted by text**[ ]  **Teams Consultations** |

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| **PLEASE INDICATE IF YOU WOULD LIKE APPOINTMENT TEXT REMINDERS SENT TO YOU:****Yes** [ ]  **No** [ ]  |

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| **Print Patient Name: Signature: Date:** **(If relevant)Print Legal Guardian Name: Signature: Date:** |

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| **Thank you for taking the time to complete this form, it will be very helpful for us when you are****seen for your appointment** |

***Please post or email completed form to the address below***

***and we will be in touch shortly***