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| **Emotional Wellbeing Service PROFESSIONALS REFERRAL FORM** | | | | | |
| We may need to contact you regarding your referral, please complete all of the following information.  Name of Referrer:  Organisation:  Address: |  | Occupation:  Telephone:  Email address: | |  | Date: |
| Please note we are not an urgent service, if this is what is required please refer to the Mental Health Response Service 01482 301701 | | | | | |
| Reason for referral (include relevant previous medical history, related physical and mental health information) Please record specific information regarding patient’s current symptoms of depression and anxiety  Please inform us if this case is veterans or perinatal (conception to 12 months post-natal) | | | | | |
| Risk of harm to self and others (include intentional/unintentional harm)  Please include any known significant alcohol or substance misuse. | | | | | |
| Please indicate the support you and/or the person being referred is seeking | | | | | |
| Does this patient have capacity to consent to this referral? Yes No (Delete as appropriate)    Does the patient consent to Assessment and the sharing of information with other professionals/agencies? Yes No (Delete as appropriate) | | | | | |
| **Personal Details** | | | | | |
| NHS Number: | | | Date of birth: | | |
| Title: First Name:  Known as: Surname: | | | | | |
| Address:  Post Code: Telephone:  Consent for postal communication Yes No  Consent to leave a voicemail Yes No  Does the patient have a **diagnosed** long term health condition? Yes No  Does the patient require an interpreter Yes No | | | | | |
| GP (if not referrer): | | | Surgery: | | |
| Nationality/Language: | | | Ethnic Origin: | | |
| Gender: | | | Religion: | | |
| Next of Kin  Name: Relationship:  Address:  Post Code: Telephone: | | | | | |
| When all sections are completed please forward to: [HNF-TR.ABService@nhs.net](mailto:HNF-TR.ABService@nhs.net) | | | | | |