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**LEEDS MENTAL WELLBEING SERVICE NHS TALKING THERAPIES**

**Professional Referral Form**

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**Please complete all sections**. If all sections are not completed the referral will be returned to the referrer or forwarded to the patient’s GP if no return address has been provided.

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| **Date of referral:** |
| **Patients Details** |
| **Name:** |  |  |  |  |  | **Title:** |
| **DOB:** |  |  |  |  |  | **NHS Number:** |
| **Patients Address:** |  |  |  |  | **GP:** |
|  |  |  |  |  |  | **GP Surgery:** |
|  |  |  |  |  |  | **Address:** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Post Code:** |  |  |  |  | **Post Code:** |
| **Preferred Telephone Contact Number:** | **Can we leave a voicemail?** Yes / No**Can we send a text?** Yes / No |
| **Patients email address:**  |  |
| *(if known and consent to being used)* |
| **Is the patient aware of the referral and consent to their information being used?** (Tick to confirm)*LMWS privacy policy: https://www.leedscommunityhealthcare.nhs.uk/about-us-new/access-to-information/privacy-notice/* | [ ]  |
| **Gender Identity***Delete as appropriate* | Male\* / Female\* / Non-binary / Other / Not disclosed \**including transgender* | **Is this the same as birth** | Yes / No |
| **Ethnicity:** |  |
| **Refugee/Asylum Status:** | **Destitute Asylum Seeker / Asylum Seeker / Refugee / Not applicable**   |
| *Delete as appropriate* |
| **Interpreter Required:**  | Yes / No | If yes, please specify language: |
| **Special Requirements:** | Yes / No | If yes, please specify: |
| **Initially we send appointment letters/emails in English.** If this is unsuitable, please advise of the best way to contact your patient: |
|  |
| **Pregnant or been pregnant in the last 12 months?** | Yes / No |
| **Is the client’s partner pregnant or been pregnant in the last 12 months?** | Yes / No |
| **Is the client a main caregiver of a child under 12 months old?** | Yes / No |
| **Referrers Details (if different to GP):** |
| **Name:** | **Job title** (*without acronyms*): |
| **Address:** | **Tel number:** |
|  |  |
|  | **Secure email address:**  |
| **Post Code:** |  |

**LMWS Therapies provide evidence-based structured treatments for common mental health problems such as anxiety disorders and depression.**

We do not treat serious mental illness (SMI). However, if somebody has an underlying **stable** SMI and a common mental health problem, we can offer treatment for their common mental health problem.

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| **Mental health information** |
| **Is the patient currently under the care of our Primary Care Mental Health Team (PCMH)?** | Yes / No |
| **Does the patient have an open referral with another mental health service?** | Yes / No |
| **If yes, please indicate which team:** |
| **Community Mental Health Team (CMHT)** [ ]  **Crisis** [ ]  **Forward Leeds** [ ]  **Connect** [ ]  |
| **Other mental health service** (*please specify*)**:** |
| **Does the patient have a diagnosis of any of the below:** |
| Bipolar [ ] Personality disorder[ ] Schizophrenia[ ] Eating Disorder[ ] Schizoaffective disorder[ ]  |
| **If the patient has a diagnosis of any of the above, please answer the below 4 questions:** |
| Have they been in secondary care services in the past 12 months  | **Yes / No** |
| If prescribed any psychotropic medication, please specify: | **Yes / No** |
| If yes, have they had any changes with this medication in the past 12 months? | **Yes / No** |
| Have there been any active symptoms or changes to their SMI in the last 12 months | **Yes / No** |

 **LMWS Therapies is not an immediate support service. If the patient needs immediate support, please refer them to the Single point of Access on 0800 183 1485**

Please provide information below regarding the common mental health problem the patient wishes to address through therapy.

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| **Common mental health problem the patient is presenting with:** *(please select)* |
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| **Depression** | **Anxiety** | **Social Anxiety** | **Health Anxiety** | **Obsessive Compulsive Disorder** |
| **Panic** | **Stress** | **Low self esteem** | **Post-traumatic stress disorder** | **Other***(please specify below)* |
| **Please provide a brief reason for recommending this patient for therapy:** |
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| **Safety and Risk Information** |
| **Risk factors** | **Please indicate** | **If YES, please provide below details:** |
| *Current thoughts, plans, intent, frequency, and any relevant historical risk information. Please include a safety plan if one has been completed.**Current or historic risk from or to others, including any safeguarding concerns and how these are being managed (i.e. domestic violence services, MARAC).**Quantity and frequency of alcohol and substance use and support in place for this.* |
| Suicide | **Yes / No** |  |
| Harm to self | **Yes / No** |  |
| Harm to others | **Yes / No** |  |
|
| Self-neglect | **Yes / No** |  |
|
| Risk from others | **Yes / No** |  |
|
| Alcohol and substance use | **Yes / No** |  |
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**Please email the completed form to** leeds.mws@nhs.net

If you have any queries about the referral process, contact the service on 0113 843 4388 or visit our website [www.leedsmentalwellbeingservice.co.uk](http://www.leedsmentalwellbeingservice.co.uk)