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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:** | | |
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| **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 disorderSchizophreniaEating DisorderSchizoaffective 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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Common mental health problem the patient is presenting with:** *(please select)* | | | | |
|
| **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** |  |
|

**Please email the completed form to** [leeds.mws@nhs.net](mailto: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)