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| **Emotional Wellbeing Service PROFESSIONALS REFERRAL FORM** | | | | | |
| Name of Referrer:  Organisation: |  | Occupation:  Telephone: | |  | 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:  Email address:  Consent to call Yes  No  Consent to leave a voicemail Yes  No    Consent to email Yes  No  Consent for postal communication Ye s 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:  Email: [HNF-TR.ABService@nhs.net](mailto:HNF-TR.ABService@nhs.net) | | | | | |