**Referral Form**

Please return this form to vitahealthgroup.refer.bnssg@nhs.net

**VitaMinds provide a short-term psychological therapies service only, suitable for mild to moderate common mental health problems, or severe stable presentations.** To enable us to process this referral, we require the form below to be completed in full.

**Please Note**: If signs of psychosis or higher risk (suicidal intent, plan) are present please refer to Primary Care Liaison Service.

**Consent:** By submitting this form you are confirming that the patient has consented to a professional referral to our service.

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| **Patient Details** |
| NHS Number: |  |
| Title: |  |
| First Name(s): |  |
| Surname: |  |
| Address: | POST CODE:  |
| Telephone Numbers: |  |
| Home: |  |
| Can we leave a message? Y/N |  |
| Mobile: |  |
| Can we leave a message? Y/N |  |
| Date of Birth: |  |
| Gender: |  |
| Ethnicity: |  |
| Sexuality: |  |
| Disability: |  |
| Religious group: |  |
| Access needs (please detail any language, religious or other requirements, e.g. is an interpreter required, learning difficulties, cultural requirements etc.) |  |

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| **GP Details** |
| GP Surgery Name and Address: |  |
| GP Surgery phone number |  |

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| **Referrer Details (only complete if referrer is NOT the GP)** |
| Name of referrer: |  | Organisation: |  |
| Telephone: |  | Email: |  |

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| **Reason For Referral**Include probable common mental health diagnosis (e.g. Depression, GAD, OCD, Phobia, Panic Disorder, PTSD, Body Dysmorphia, Illness Anxiety) |
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| **Drug/Alcohol Use**Current and historical dependency on substances |
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| **Risk Information** We require information about **past/current suicide and self-harm risk,** any **risk to others** and **risk management plans**: |
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| **Please Indicate if Patient Falls within These Groups:** |
| Perinatal period (pregnancy & first 2 years after childbirth) |  | Veteran |  |

**Please attach relevant assessment documentation/risk management plans wherever possible as these will greatly support our decision making.**