**Referral to the Adult Complex Needs Service**

**All sections of the form are compulsory and must be completed to ensure the referral is accepted.**

Fields highlighted in blue (\*) are required. In order to successfully save this document, please ensure the required fields are completed.

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| **Date of Referral** | Click here to enter a date. |  |

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| **Patient Details** | | | | | |
| **Full Legal Name \*** |  | | **Date Of Birth** | Click here to enter a date. | |
| **Preferred name (if different)** |  | | **Sex assigned at Birth \*** | Male | Female |
| **Address** |  | | **NHS Number** |  | |
| **Post Code** |  | **Patient Mobile** |  | |
| **Patient Email** |  | | **Patient Telephone** |  | |
| **Interpreter Required? \*** | **Yes** | **No** | **If required, what language** |  | |
| **Do the patient have any other communication support needs? \*** | **Yes** | **No** | **If yes, please give more information** |  | |
| **Can the patient attend the clinic independently \*** | **Yes** | **No** | **If no, please give more information** |  | |
| **Marital status \*** | Choose an item. | | **Ethnicity \*** | Choose an item. | |
| **Employment status \*** | Choose an item. | | **Current accommodation \*** | Choose an item. | |
| **Is the patient an ex-member of British armed forces or dependent on such a person? \*** | | | **No**  **Unknown**  **Yes, ex-services member**  **Yes, dependant of an ex-services member** | | |

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| **GP Details** | | | |
| **GP Name** |  | **GP Practice Name** |  |
| **GP Address** |  | **GP Telephone** |  |
| **GP Fax** |  |
| **GP E-mail** |  |

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| **Referrers Details** (*only if the referrer is* ***not*** *the patient’s GP)* | | | |
| **Referrer Name** |  | **Referrer Job Title** |  |
| **Referrer Address** |  | **Referrer Telephone** |  |
| **Referrer Fax** |  | **Referrer E-mail** |  |

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| **Primary Reason for Referral (Especially why your patient asks for psychotherapy now) \*** |
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| **Medical, Psychiatric and Psychotherapeutic History including risks, excessive alcohol and drug misuse**  *Including computerised printout* |
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| **Information of Early History and Current Life in Relationships** | | | |
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| **Current Medications**  **Prescribed and non-prescribed (including hormones, contraceptives and herbal medicines)** | | | |
| **Name** | **Dose** | **Prescribed by/ obtained from** | **Duration** |
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| **Any other relevant information or comments** | | | |
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| **Referrer’s Signature:\*** | **Referrer’s Job Title** | **Date:** |
| **Option1:**  **I (upload image of signature)**  **OR**  **Option2:** Type name here  **(enter name)** |  | Click here to enter a date. |