**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** |
|       |
| **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. |