**CLINICAL PSYCHOLOGY (HEALTH) REFERRAL FORM**

|  |
| --- |
| **PLEASE NOTE*** *Clinical Psychology does not offer an emergency/crisis service.*
* *We may request additional information or decline referrals if they do not meet our referral criteria (as outlined in the reason for referral section of this form).*
* *Please discuss the referral with the patient (and their caregivers where required) before referring. We are unable to see people who have not given informed consent.*
* *For inpatients, we only offer a one-off consultation unless otherwise funded by the ward/ department.*
* *If your referral is for BOTH the patient AND a family member, please complete a separate form for each so we can be clear what the specific individual needs/difficulties and support asks are.*
 |

|  |
| --- |
| **CONSENT** |
| Has the person been informed of and agreed to the referral? Yes 🞎 No 🞎 |
| For under 18s, have those with parental responsibility also been informed of and agreed to the referral? Yes 🞎 No 🞎 N/A 🞎 |
|  |
| **PATIENT DETAILS** |
| **Patient name:** |  |
| **Hospital number:** |  |
| **Date of birth:** |  |
| **Address:** |  |
| **Patient status:**  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Outpatient | 🞎 | Inpatient | 🞎 | Ward: | EDD: |

 |
| **Named consultant:** |  |
| **Armed forces:** |

|  |  |  |  |
| --- | --- | --- | --- |
| Military service person | 🞎 | Military veteran | 🞎 |

 |
| **If the referral is for family member, please provide details:** |
|

|  |  |
| --- | --- |
| Name: | Relationship to patient: |
| Hospital number: | Date of birth: |
| Contact telephone number: |
| Home address: |
| Name and address of registered GP: |

 |
|  |
| **HEALTH INFORMATION** |
| **Key information regarding physical health condition:***(Where relevant, including reason for admission, current investigations, treatment, prognosis)* |
| **If inpatient, is this person well enough to engage?** (e.g. not over-sedated or experiencing delirium) Yes 🞎 No 🞎 |
|  |
| **REASON FOR REFERRAL TO CLINICAL PSYCHOLOGY (HEALTH)***(Please tick at least one box and provide details)* |
|

|  |
| --- |
| Pre-surgical assessment 🞎 |
| Psychological difficulties/distress affecting: |
| Assessment/diagnostics | 🞎 | Treatment (including adherence) | 🞎 |
| Recovery/rehabilitation | 🞎 | Family psychological impact | 🞎 |
| Adjustment to experiences in hospital | 🞎 | Adjustment to physical health condition (including sense of identity) | 🞎 |

**Description of psychological difficulties and current impact** (please specify *how* psychological difficulties are impacting on diagnostic assessments, treatment, rehabilitation):*For pre-existing mental health concerns, substance misuse, or significant risk to self/others, please refer to MH liaison (A&E/inpatients) or community MH or substance misuse services (outpatients)* |
| **What is the goal from psychology input?** |
| **Please complete the following screening questions with the person being referred:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Over the last two weeks how much have you been bothered by the following problems?** | **Not at all** | **Several days** | **Over half the days** | **Nearly every day** |
| 1. Little interest or pleasure doing things
 | 🞎 | 🞎 | 🞎 | 🞎 |
| 1. Feeling down, depressed, or hopeless
 | 🞎 | 🞎 | 🞎 | 🞎 |
| 1. Feeling nervous, anxious, or on edge
 | 🞎 | 🞎 | 🞎 | 🞎 |
| 1. Not being able to stop or control worrying
 | 🞎 | 🞎 | 🞎 | 🞎 |
|  |

 |
| **Is the individual currently receiving any other professional or social support for these psychological difficulties?** Yes 🞎 No 🞎If yes, who from?  |
| **Are there any time-critical considerations for psychology input?** (e.g. required timescale for surgery/treatment)Yes 🞎 No 🞎Details: |
|  |
| **SAFEGUARDING** |
| **Are there any safeguarding concerns (risk to self, from others, to others)?** *Please include verbal or physical aggression from patient or visitors to patient, and any infection prevention control issues.* Yes 🞎 No 🞎Details: |
|  |
| **REFERRER DETAILS** |
| **Name of referrer:** |  |
| **Profession of referrer:** |  |
| **Date of referral:** |  |
|  |
| **COMMUNICATION & ACCESSIBILITY NEEDS** |
| **Communication and accessibility need:** |
| Interpreter required?Yes 🞎 No 🞎 If yes, which language? | Wheelchair access required:Yes 🞎 No 🞎  |
| Hearing: | Learning disability: |
| Vision: | Other disability needing consideration: |
|  |
| ***ADMIN PURPOSES ONLY:***  | *Accept* 🞎 | *Decline* 🞎*Signposting (where appropriate):* | *Request additional information* 🞎*Details:* |