**CLINICAL PSYCHOLOGY (HEALTH) REFERRAL FORM**

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| **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.* |

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| **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 🞎 | | | | | | |
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| **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: | | | | | | | | |
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| **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 🞎 | | | | | | |
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| **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: | | | | | | |
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| **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: | | | | | | |
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| **REFERRER DETAILS** | | | | | | |
| **Name of referrer:** | |  | | | | |
| **Profession of referrer:** | |  | | | | |
| **Date of referral:** | |  | | | | |
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| **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:* |