|  |  |
| --- | --- |
| Date of Referral: Enter a Date | NHS Number:       |
| Is client aware of referral and given their consent?  | **Yes** [ ]  **No** [ ]  |
| Client Personal Details |
| Title:  | Choose an item.       | **Given Name:**  |       | **Family Name:**  |       |
| Gender:  |       | **Date of Birth:** |       | **Religion**: |       | **Ethnicity**: Choose an item |
| Client Address:  |       | **Housing status:** Permanent: [ ]  Temporary: [ ]  |
| County:  |       | Type of Accommodation: (E.g. Flat)      |
| Postcode:  |       |
| Contact Number:  | Home:       | Mobile:       |
| Email:  |       |
| Messages: Can a text message be sent? Can a message be left on voicemail?  Consent given to send e-mails? (Has the client been made aware of risks of sending messages via email?  | Yes [ ]  No [ ]  Yes [ ]  No [ ]  Yes [ ]  No [ ]  Yes [ ]  No [ ]   | Any instructions from client:       |
| Does the client have any communication difficulties? | Yes [ ]  No [ ]  If yes please stipulate:       |
| Next of Kin |
| Title:  | Choose an item. | **Given Name:**  |  | **Family Name:**  |       |
| Relationship:(e.g. partner, family member, friend, neighbour etc.) |       |
| Address:  |       |
| Contact Number:  | Home:   | Mobile:       |
| Email: |       |
| Permission given to contact Next of Kin? | Yes [ ]  No [ ]  | Comment:       |
| Military Service Details |
| Service Number (Required): |       | **Service:** | Choose an item.       |
| Rank on Discharge: |       | **Unit/Regiment:** |       |
| Enlistment date: |       | **Discharge date:** |       |
| Trade/Role: |       | **Discharge reason if known:** | Choose an item.        |
| If client is currently serving: | Regular [ ]  Reserves [ ]  | **Discharge due Date**: | Enter a date. |
| Operational deployments (Include dates if possible):  |       |
| Traumatic events related to military service: (Please provide a very brief outline of the trauma) |       |
| Client’s GP Details |
| GP’s Name: |       | **Practice Name**: |       |
| Practice Address: |       | **Contact Number**: |       |
| Email/s: |       |
| Referrer Details  |
| Referrer Name: |       | Referred by:  | Choose an item. If Other:       |
| Rank / Title / Position: |       | Service / Organisation: |       |
| Address: |       | Telephone: |       |
| Postcode: |       | Mobile: |       |
| Email: |       |
|  |
| Other Services Involved(E.g. The Royal British Legion, Help 4 Heroes, STOLL, Veterans Outreach Support, etc..) |
| Service | **Name of service:** | **Name of Professional/Contact:** | **Contact details:****(Address and Tel No)** |
| Department of Community Mental Health (DCMH): |       |       |       |
| Personnel recovery Unit (PRU): |  |  |  |
| Local Authority: |  |  |  |
| NHS: |  |  |  |
| Private sector: |  |  |  |
| 3rd Sector: (E.g. Charities, voluntary etc) |  |  |  |
|  |
| Presenting Problem – Reason for ReferralIn the client’s own words (If possible), why they are asking for help: |
|       |
| Any Previous Mental Health Problems and/or Contact with Mental Health Services? Yes [ ]  No [ ]  If yes, please give details: |
|       |
| Are there any significant risk issues to client or others? Yes [ ]  No [ ]  If yes, please give details: |
|       |
| Current Substance Use:Is the client using alcohol? Yes [ ]  No [ ]  Is the client using other substances? Yes [ ]  No [ ] If yes, please give details regarding substance used, amount and frequency: |
|       |
| Does the Client have any children? Yes [ ]  No [ ]  Do they live with the Client? Yes [ ]  No [ ]  If children are under 18 please provide names and Dates of Birth |
|       |
|  |
|  |  |  |  |
| Does the Client have any physical health problems? Yes [ ]  No [ ] If yes, please provide details:  |
|       |
| Does the Client consider themself to have a disability? Yes [ ]  No [ ] If yes, please provide details:  |
|       |
| Does the Client have any accessibility needs? (e.g. can’t climb stairs, use of crutches/ wheelchair etc) Yes [ ]  No [ ] If yes, please provide details:  |
|       |

*Email referral to:* *snhs.veteranshis.se@nhs.net*

**Our service does not provide emergency care. In the event of an emergency please contact your GP, local crisis number, attend your nearest A&E Department or dial 999.**

**Consent to Release Medical and Service Information**

Name:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service Number:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| I give consent for the Veterans’ Mental Health Service – (High Intensity Service) to request verification of my military service with the Ministry Of Defence and if necessary to request copies of my service and/or medical records (e.g. from DCMH, PRU and/or DMS). | Yes [ ]  No [ ]  |
| I give consent for my medical records, if necessary, from my General Practitioner (GP) to be provided to Veterans’ Mental Health Service – (HIS). | Yes [ ]  No [ ]  |
| I give consent for my information to be shared with my General Practitioner (GP).(**Note: Your referral may not be able to proceed if you do not consent for us to share information with your GP**) | Yes [ ]  No [ ]  |
| I understand that I have the right to withdraw my consent at any time by: * Speaking to staff at the Veterans’ Mental Health Service – (HIS)
* Letter (Insert address of HIS when address confirmed)
* Phone (Insert phone number when confirmed )
* Email (Insert email number when confirmed)
 | Yes [ ]  No [ ]  |
| I give consent for my information to be used anonymously for research and service evaluation purposes. | Yes [ ]  No [ ]  |

Information shared with the services indicated above shall be: the minimum necessary; in compliance with both the Data Protection Act (2018) and the General Data Protection Regulation (GDPR, 2016); and accessed only by appropriate staff on a need to know basis.

Signature:      **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date: Enter a date.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_