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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 Referral  In 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 | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | |  | | | | | | |  | | | | | | | | | |  | | |
| 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*](mailto: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.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_