|  |
| --- |
| **INTRODUCTION(READ THIS FIRST)**  We invite referrals of individuals who present with **common mental health problems** (e.g. depression, anxiety, relationship issues, loss, and bereavement) and distress or adjustment issues around long term health condition, diabetes and COPD. We offer a range of psychological interventions to those aged 18 and above who lives in Newham or are registered with a Newham GP.  We do not have upper age limit and we actively encourage referrals for over 65’s. However, older adults with age-related issues (e.g. dementia) should be referred to Mental Health Care for Older People.  ***We are not a crisis service.*** If you or anyone else is in immediate danger or harm, please call 999. The 24-hour Mental Health Crisis Line can be accessed by calling 111, pressing option 9 to continue, then saying “NEWHAM” and pressing option 2 for Mental Health. Alternatively, you can call the Samaritans 24 hours a day, 7 days a week on 116 123.  Individuals with severe, enduring and complex mental health problems (e.g. psychosis, personality disorders, bipolar, risks to self and others) should be referred to Community Integrated Mental Health Team, East Ham Memorial Building 298 Shrewsbury Road, London E7 8QP, Tel: 020 3288 5100 (Note: This was previously known as part of the Assessment and Brief Treatment Team)  We will be grateful if you could fill in as much information below as possible. Please make sure telephone numbers are up to date and inform the patient that we will call them from an NHS phone number that will show as unknown on their mobile telephone. Email the completed form to elft.ntt-referrals@nhs.net  If you have any questions or if there is anything we can do to facilitate your referral, please feel free to call us on 0208 175 1770. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Client details** | | | | |
| **NHS No:** |  | | **Rio No:** |  |
| **Title:** | **First name:** | **Surname:** |  |  |
|  |  |  | **Ethnic Origin:** |  |
| **Address**: |  | | **Interpreter required:** |  |
| **Telephone No:** |  | | **Permission to contact by phone?** Yes  No | |
| **Mobile:** |  | | **Permission to leave messages on your home telephone?**  Voice message  Text message | |
| **Date of Birth:** |  | | **Permission to leave messages on your mobile?**  Voice message  Text message | |
| **Gender:** |  | | **Permission to send written communication?** Yes  No | |
| **Email:** |  | | **Permission to contact by email?** Yes  No | |

|  |  |  |
| --- | --- | --- |
| **GP details** | | |
| **GP name:** | |  |
|  | | |
|
| **Telephone No:** |  | |
| **GP's Fax No:** |  | |

|  |
| --- |
| **Referrer details only complete this section if the referrer is not a GP. (If GP practice leave blank)** |
|  |

|  |
| --- |
| **Referrer Information**  **(**Please feel free to provide any further information on separate sheet or attach any relevant documents as deemed appropriate) |
| **List of significant diagnosis**  **1. Identified problems and what would you like us to provide?**  If possible, we would be grateful if you could include history of your patient’s difficulties, duration & diagnosis.  **2.a Has this referral been discussed with patient?** Yes  No  **2.b What does the patient hope to get out of a referral to talking therapy? E.g. feeling better, less depressed.**  **3. Is there any immediate concern about risk to self or others which require urgent attention?**  Yes  No  **If yes –do not proceed with this referral. Refer to a CMHT**  **If no, are there other concerns regarding risk to self or others we should be aware of?**  **4. Alcohol/substance misuse?** Yes  No  **If yes please provide more information**  **5. Please specify if the patient has a primary problem of:**  Diabetes  COPD  Other Long Term Health Condition  please specify  **6. Is your patient currently under the care of Psychiatric or specialist team for their psychological problems?**  Yes  No  **If yes, which team**  **7. Any relevant/important information you think would be helpful for us to know?** |