|  |  |
| --- | --- |
| **Service Referral** | **Adult Psychology referral** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
| **PATIENT DETAILS** | | | | | | | | | | | | |
| Patient Name: | | | | |  | | | | Date of Birth: | |  | |
| Address: | | | | |  | | | | Hospital Number: | |  | |
|  | |  | |
| NHS Number: | |  | |
| Sex: | |  | |
| Phone No: | | | | |  | | | | GP: | |  | |
|  | | | | | | | | | | |
|  | | |  | |  | | | |  | |
|  | | |  | |  | | | |  | |
|  | | |  | |  | | | |  | |
|  | | |  | |  | | | |  | |
|  | | |  | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | |  | | | | | | |
|  | | |  | | | | | |
| Has the patient agreed to the referral? | | | Yes No | | | | | |
| Patient preferred contact number (mobile if possible) | | |  | | | | | |
| Do they give permission to leave messages on answerphone if no reply? | | | Yes No | | | | | |
| Reason for referral | | | Adjustment/coping Anxiety (general) Stress Anxiety about the future (e.g. returning to work or education, guilt) Anxiety around medical procedures Body Image Issue Concerns around changes to health Coping with hospital admissions End of life Family issues Relationship difficulties Issues around decision making Low confidence and self-esteem Low mood Managing nausea Pain Problems with anger Problems with food or eating Problems with managing treatment Problems with sleep Trauma Other - Specify below | | | | | |
|  | | | | | | | | |
| Please provide details of reason for referral | | |  | | | | | |
| What is the impact on patient/family/treatment/staff | | |  | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Are they an inpatient at present? | Yes No | If yes please state ward and expected date of discharge |  |
| Other medical information (if relevant): e.g. prognosis, palliative treatment, complications, metastatic disease **(if cancer service, please note primary diagnosis)** |  | | |
| If this is a Cystic Fibrosis patient, is the patient an infection risk? | Yes No n/a |  |  |
| Is there an issue with engagement with treatment and/or the service? | | Yes No | |
| If yes, please provide details |  | | |
| Does the patient have a known psychological /psychiatric history? | | Yes No Unknown | |
| If yes please provide details including the Mental Health Services involved |  | | |
| Other relevant information (including social and family history) |  | | |

|  |  |
| --- | --- |
| Is the patient at immediate risk of harm to self or others? | Yes No |
| If yes, please refer to Liaison Psychiatry (inpatient) or GP/crisis team (outpatient) | |

If you are unable to raise this request yourself on equest please complete this form and submit to [wendy.spencer@uhs.nhs.uk](mailto:wendy.spencer@uhs.nhs.uk) who will raise directly onto equest for you.