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| **Referral Form – East of England**This form asks a number of questions to help us understand the situation as best as possible at this preliminary stage, but please only answer as much as you feel able to at this time.If you need help completing this form, please call our referral line on 0300 034 9991 and we will take a telephone referral. |
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| **Support Team Call Handler Name (MHM use only):**  | **Referral type: (MHM use only)****Telephone self-referral** [ ] **Telephone professional** [ ] **Email self-referral** [ ] **Email professional referral** [ ]  | **Referral Number:** **(MHM use only)** |

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| **Date of Referral:** | **Date of Birth:**  | **Gender identification:**  |
| **Client Name:** | **Ethnicity:** | **NHS number (if known):** |
| **Client Address:** Permanent [ ]  Temporary [ ] **Telephone Number:** **Leaving Voicemail?** **Yes** [ ]  **No** [ ] **Email Address:****Do you consent to us contacting you by:****Post?** **Yes** [ ]  **No** [ ] **Text Message?** **Yes** [ ]  **No** [ ] **Email? Yes** [ ]  **No** [ ] Any communication difficulties or considerations (I.E. is an interpreter needed)? | **Branch of Armed Forces:**Army [ ]  Royal Navy [ ]  RAF [ ]  Royal Marine [ ] **Regular or Reserve:** Regular [ ]  Reserve [ ] **Service Number (required for referral): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Year Enlisted:\_\_\_\_\_\_\_** | **Year Discharged: \_\_\_\_\_\_\_\_** |

**If still serving, do you have a discharge date?** **Date \_\_\_\_No** [ ] **Regiment and rank on discharge:****Were you Deployed Operationally? Yes** [ ]  **No** [ ] If yes, please state each tour with approximate year completed: |
| **GP Details****GP’s Name:****Practice Name:****Practice Address:****Contact Number:****Email Address:**  | **Referrer Details** (if not a self-referral)**Referrer Name:** **Position/Role:****Address:****Contact Number:****Email Address:****Is the patient aware and has given consent for the referral to be made?** Y [ ]  N [ ]   |
| **Next of Kin – in case of emergency**(e.g. partner, family member, friend, neighbour etc.)**Name:****Relationship to Client:****Address:****Contact Number:****Email Address:**  | **How did you hear about Op COURAGE?** |
| **Are there other services currently involved in your care (e.g. Royal British Legion, Op NOVA, Op RESTORE, VETERANS UK, DCMH, NHS mental health services)? Yes** [ ]  **No** [ ] If yes, please provide details below:**Name of Professional: Service: Contact Details:** **For professional referrals only:****Is the person high risk to self/others, or using NHS crisis/in-patient services? Yes** [ ]  **No** [ ]  UNSURE[ ] **Please note: our Service does not provide 24-hour emergency care or function as crisis response. If this individual is experiencing a mental health crisis, please refer to the local NHS crisis team in the first instance directly or by contacting NHS 111 option 2** |
| **MENTAL HEALTH AND WELLBEING****In your own words, please describe below what difficulties you (or the person you are referring) experience and what you would like help with:** *Please Consider the following:**Symptoms such as low mood, worry/anxiety, lack of sleep, anger, intrusive thoughts/images etc.**Previous Mental Health diagnosis**Impact of symptoms on daily tasks**Duration of difficulties**What type of support does the Veteran think they need?**Current situational/social circumstances issues and how they are impacting the Veteran***Do you think you experience:*** Difficulties related to your time in the military **Yes** [ ]  **No** [ ]  If yes, please provide details:

**Please provide details of any previous mental health treatment and/or contact with mental health services:** |
| **SAFETY:****Risk to self:**Do you feel you are a risk to yourself?Yes [ ]  No [ ] **If yes:*** **Over the last two weeks, have you had any thoughts of hurting yourself in some way:**

Not at all [ ]  Several days [ ]  More than half the days [ ]  Nearly every day [ ] Brief description of the risk:* **Any history of suicidal thoughts or actions:** **Yes** [ ]  **No** [ ]

**If no**:* **Any history of suicidal thoughts or actions:** **Yes** [ ]  **No** [ ]

Brief description of history: |
| * **Are you worried about risk of harm from anyone else?** **Yes** [ ]  **No** [ ]

If yes, please provide a brief description of the risk:* **Are you worried you may be/are a risk to anyone else:** **Yes** [ ]  **No** [ ]

If yes, please provide a brief description of the risk:* **Do you have any children under 18 living with you? Yes** [ ]  **No** [ ]

If yes, please provide brief details including ages of dependents:* **Do you identify as a carer for anyone else? Yes** [ ]  **No** [ ]

**To help us identify if there are other Veterans services that might also be of help to you (e.g. Op NOVA), do you have any current forensic convictions/ restrictions in place?** Y [ ]  N [ ]  **or any current involvement with police or probation?** Y [ ]  N [ ]  If yes, please give details and any relevant contact details. **Does the veteran have any current involvement with safeguarding/social care?** Y [ ]  N [ ] If yes, please give names and contact details.  |
| **GENERAL HEALTH:****Do you have any physical health diagnoses or concerns? Yes** [ ]  **No** [ ] If yes, please give details: **Do you consider yourself to have a disability?** Yes[ ]  No [ ] If yes, please give details:**Do you have any accessibility needs?** (e.g. housebound, use of crutches/ wheelchair, hearing difficulties, sensory needs, visual impairment etc.) **Yes** [ ]  **No** [ ] If yes, please give details:**Do you have any drug or alcohol needs that you might need support with? Yes** [ ]  **No** [ ] If yes, please give details: |
| **For MHM staff only:****Any actions taken by handler (e.g. helpline number provided, other organisations signposted):** |

**Consent and confidentiality**

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| Veteran consented to referral being sent to East of England Op COURAGE Hub. Information shared with the services indicated below 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. There may be specific situations related to risk to self or others where confidentiality can be broken. | **Yes** [ ]  **No** [ ]  |
| I give permission for assessment and care information to be shared with my GP and my medical records to be requested from my GP by Op COURAGE, if clinically required. | **Yes** [ ]  **No** [ ]  |
| I give consent to referral information being shared by the East of England Op Courage with other agencies involved in the assessment and care-planning process as appropriate, such as Op Courage partners (A full list of partners is provided below), local authority, housing department or other NHS organisations. | **Yes** [ ]  **No** [ ]  |

In order to help us best understand your needs, we may require information about; your current and past treatment, housing, welfare rights, or social care support. We may also need to share referral information with other organisations. This would only be for reasons connected to your care and safety. Any information shared will be documented on your mental health clinical records. **Please read and sign the below consent document.** You have the right to contact the team and withdraw consent at any time.

**East of England Op Courage Partnerships:**

* The Warrior Programme
* Walking With The Wounded
* Norfolk and Suffolk NHS Foundation Trust
* Mental Health Matters
* Dr Julian Therapies
* St Andrews Healthcare

Consent provided by client: Via self-referral [ ]  Via Call handler [ ]  Via Referrer\_\_[ ]

Electronically signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **A member of the service will contact you once the referral has been reviewed by the multi-disciplinary clinical team.****Please return completed forms to our single point of access:****Email:** **mevs.mhm@nhs.net****Tel: 0300 034 9991** **24/7 emotional helpline is available: 0300 323 0139** |