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| **Referral Form – East of England**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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| **Date of Referral:** | **Referral type: (MHM use only)****Telephone self-referral** [ ] **Telephone professional** [ ]  | **Referral Number:** **(MHM use only)** |
| **Support Team Call Handler Name (MHM use only):**  |

 |
| **Client Name:** | **Date of Birth:**  | **Gender identification:**  |
| **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. In an emergency, you should contact NHS 111 option 2 for Mental Health, attend your nearest A&E Department or dial 999.** |
| **Client Address:** Permanent [ ]  Temporary [ ] **Telephone Number:** **Email Address:****Do you consent to us contacting you by:****Post?** **Yes** [ ]  **No** [ ] **Text Message?** **Yes** [ ]  **No** [ ] **Leaving Voicemail?** **Yes** [ ]  **No** [ ] **Email? Yes** [ ]  **No** [ ]  | **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: \_\_\_\_\_\_\_\_** |

**Are you Currently Enlisted?** **Yes** [ ]  **No** [ ] **If yes, do you have a discharge date?** **Yes** [ ]  **No** [ ] **Rank on discharge:****Were you Deployed Operationally? Yes** [ ]  **No** [ ] If yes, please state each tour with approximate year completed: |
| **NHS Number:** |
| **Ethnicity:** |
| **Nationality:** |
| **Religion:** |
| **Sexual Orientation:** |
| **Relationship Status:** |
| **Employment Status:** |
| **How did you hear about Op COURAGE?** |
| **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:** |
| **Next of Kin – in case of emergency**(e.g. partner, family member, friend, neighbour etc.)**Name:****Relationship to Client:****Address:****Contact Number:****Email Address:**  | **Do you have someone that supports you day-to-day?** **Yes** [ ]  **No** [ ]  **Do you consent to them to being contacted if required?** **Yes** [ ]  **No** [ ]  **Do they require information, advice, or support from us? Yes** [ ]  **No** [ ]  Don’t Know [ ] **Name of person:Relationship to Client:****Address:****Contact Number:****Email Address:**  |
| **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: *(Consider symptoms, daily impact, duration of difficulties, what type of support you think you need, readiness to engage in treatment)*****Do you think you experience:*** Low mood **Yes** [ ]  **No** [ ]
* Worry/anxiety **Yes** [ ]  **No** [ ]
* Ongoing problems due to traumatic life experiences **Yes** [ ]  **No** [ ]
* Difficulties related to your time in the military **Yes** [ ]  **No** [ ]  If yes, please provide details:

**Please provide details of any previous mental health difficulties, diagnoses, treatment and/or contact with mental health services:****Are there other services currently involved in your care (e.g. RBL, Op NOVA, Op RESTORE, VETERANS UK, DCMH)? Yes** [ ]  **No** [ ] If yes, please provide details below:**Name of Professional: Service: Contact Details:**  |
| **SAFETY:*** **Over the last two weeks, have you had any thoughts that you would be better off dead or hurting yourself in some way:**

Not at all [ ]  Several days [ ]  More than half the days [ ]  Nearly every day [ ] * **Any history of suicidal thoughts or actions:** **Yes** [ ]  **No** [ ]
* **Are you worried about risk from anyone else?** **Yes** [ ]  **No** [ ]
* **Are you worried you may be/are a risk to anyone:** **Yes** [ ]  **No** [ ]
* **Do you have any children under 18 living with you? Yes** [ ]  **No** [ ]
* **Do you identify as a carer for anyone else? Yes** [ ]  **No** [ ]
* **Any current forensic convictions/restrictions in place? Yes** [ ]  **No** [ ]
* **Any current involvement with police or probation?**  **Yes** [ ]  **No** [ ]
* **Are you using alcohol to a harmful level? Yes** [ ]  **No** [ ]
* **Are you using non-prescribed drugs? Yes** [ ]  **No** [ ]  If yes, please give basic details regarding substance used, amount and frequency:

If yes to any of the above, please give details: |
| **GENERAL HEALTH:*** **Do you have any physical health diagnoses or concerns? Yes** [ ]  **No** [ ]
* **Do you smoke?** **Yes** [ ]  **No** [ ]
* **Do you consider yourself to have a disability?** Yes[ ]  No [ ]
* **Do you have any accessibility needs?** (e.g. housebound, use of crutches/ wheelchair, hearing difficulties, sensory needs, visual impairment etc.) **Yes** [ ]  **No** [ ]

If yes to any of the above, please provide details: |
| **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** |

**Consent to Release Service and Medical Information**

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.

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| I give permission for Essex Partnership NHS University Foundation Trust (lead provider of Op COURAGE East of England Veterans Mental Health Service) to verify my military service with the MOD if required, and, if clinically necessary, to request copies of my service and/or medical records (e.g. from DCMH, PRU and/or DMS) | **Yes** [ ]  **No** [ ]  |
| I give permission for my General Practitioner (GP) medical records to be requested by Op COURAGE, if clinically required. | **Yes** [ ]  **No** [ ]  |
| If necessary to meet my agreed support needs, I give permission for relevant records to be shared between organisations such as the local authority, housing department or other NHS organisations.  *Please note we would discuss any onward referrals with you first.* | **Yes** [ ]  **No** [ ]  |
| I give permission for assessment and care information to be shared with my GP.(NB: as a health service we are unable to proceed with your referral if you do not consent for us to share clinical information with your GP, however we may consider specific requests if this does not impact necessity for clinical communication) | **Yes** [ ]  **No** [ ]  |
| I give consent for my care requirements to be shared with the appropriate provider within the East of England Op COURAGE service. Our service has health and social wellbeing partnerships with; The Warrior Programme, Walking With The Wounded, Norfolk and Suffolk NHS Foundation Trust, Mental Health Matters, Dr Julian Therapies, and St Andrews Healthcare. Therefore, some aspects of your care may be provided by these organisations either during or after your Op COURAGE referral.  | **Yes** [ ]  **No** [ ]  |

**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. Please contact us with any questions about information sharing and consent.**

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

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