

Blackpool Healthier Minds -for people with Long Term Health Conditions

Referral Form

Patients Details	Referrers Details
<p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Postcode: _____</p> <p>Telephone number: _____</p> <p>Mobile: _____</p> <p>Can we leave voicemail messages? Yes/No</p> <p>Can we send text messages? Yes/No</p> <p>Email: _____</p> <p>Can we contact you by email? Yes/No</p> <p>NHS Number: _____</p> <p>Date of Birth: _____</p> <p>GP Practice: _____</p> <p>Ethnicity: _____</p>	<p>Name: _____</p> <p>Service: _____</p> <p>Telephone number: _____</p> <p>Mobile: _____</p> <p>Email: _____</p> <p>Referrer Designation: _____</p> <p>_____</p> <p>Is the client aware of the referral?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Is the patient (or partner) pregnant or have caring responsibility for a child under 24 months?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>Next of Kin/Emergency Contact Details</p> <p>Relationship : _____ Name _____</p> <p>Address: _____ Telephone number: _____</p>	
<p style="text-align: center;">Referral Information</p>	
<p>Long Term Physical Condition: (Please tick and give date of diagnosis)</p> <p>COPD / Respiratory Disorder</p> <p>Diabetes</p> <p>MSK problems</p> <p>Chronic Pain</p> <p>Rheumatology -</p> <p>Cardiovascular Disease</p> <p>IBS</p> <p>ME</p> <p>Fibromyalgia</p>	<p>Mental Health Problem: (Please tick)</p> <p>Anxiety</p> <p>Panic attacks</p> <p>Depression</p> <p>Excessive worrying</p> <p>Unhelpful or distressing thoughts</p> <p>Other – give details</p>



Does the patient have any support around their mental health problem? (Already involved with mental health services?) Please give details:

What is the impact of the patient's mental health problem on their physical health?

Does the patient have any physical health needs that may impact on them attending sessions?

**Are there any risks to be aware of?
(Suicidal thought/self-harm/neglect/substance misuse)**

CONSENT TO SHARE INFORMATION

Please sign the statement below if you give your consent for information to be shared.

I give my consent for the information contained in this referral to be shared with the Healthier Minds Team.

Print name

Signed

Date

Please send to: bfwh.healthierminds@nhs.net