

 **Humber Teaching NHS Foundation Trust
St Andrew’s Place, 271 St George’s Road
Hull, HU3 3SWT
Tel:  01482 335479
Email:****hnf-tr.opcouragehumberandnorthyorkshire@nhs.net**
[**https://www.humber.nhs.uk/Services/veterans-mental-health-and-welbeing-service.htm**](https://www.humber.nhs.uk/Services/veterans-mental-health-and-welbeing-service.htm)

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| **Professional Referral Form** **PLEASE RETURN COMPLETED REFERRAL FORM TO:** **hnf-tr.opcouragehumberandnorthyorkshire@nhs.net** |
|  **Date of Referral** |  |
| **Name of veteran including title** **(Mr / Mrs / Other, please state)** |  |
| **Have you ever been known as a different name or did you serve under a different name? if so, what was it?** |  |
| **Gender:** |  |
| **Sexual Orientation (if known):** |  |
| **Pronouns (If known):** |  |
| **Date of Birth:** |  |
| **Address:**  |  |  |
| **Is the address:** | Permanent [ ]  Temporary [ ]  |
| **Telephone Number/s:** |  |
| **What is your preferred time to be contacted?** |  |
| **Email Address:** |  |
| **Do you consent to us contacting you by:** | **Phone** | Yes [ ]   | No [ ]  |
| **Letter to the above address** | Yes [ ]   | No [ ]  |
| **Text Message?** | Yes [ ]   | No [ ]  |
| **Voicemail Message?** | Yes [ ]   | No [ ]  |
| **Email**?  | Yes [ ]   | No [ ]  |
| **NHS number:** |  | **Relationship Status:** |  |
| **Ethnicity:** |  | **Nationality:** |  |
| **Religion:** |  | **Employment Status:** |  |
| **Communication Difficulties?**  | Yes [ ]  No [ ]  If yes please specify: |
| **How did you hear about OpCourage?** |  |

**Referrer Details**

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| **Referrer Name:** |  |
| **Position/Role:** |  |
| **Address / Mental Health Trust:** |  |
| **Contact Number:** |  |
| **Email Address:** |  |

**GP Details**

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| **GP Name:** |  |
| **Practice Name:** |  |
| **Practice Address:** |  |

**Military Service Details**

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| --- | --- |
| **Branch of Armed Forces:** | Army [ ]  Royal Navy [ ]  RAF [ ]  Royal Marine [ ]   |
| **Regular or Reserve:**  | Regular [ ]  Reserve [ ]   |
| **Service Number:**  |  |
| **National Insurance Number:** |  |
| **Service Dates:** | Enlistment Date (DD/MM/YYYY) | Discharge Date (DD/MM/YYY) | Length of Service |
|  |  |  |
| **Are you Currently Enlisted?**  | Yes [ ]  No [ ]   | If yes, do you have a discharge date?  | Yes [ ]  No [ ]   |
| **Rank on discharge:** |  |
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| **Were you Deployed Operationally?**  |  Yes [ ]  No [ ]   | If yes, please state each tour with approximate years: |
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**Next of Kin**

|  |  |
| --- | --- |
| **Relationship to you:**(Partner, family member, friend, neighbour etc.) |  |
| **Is it OK for them to be contacted in an emergency?**  | Yes [ ]  No [ ]   |
| **Address:** |  |
| **Contact Number:** |  |
| **Email Address:** |  |

**Carer**

|  |  |
| --- | --- |
| **Do you have a carer/family member/friend that supports you day-to-day?** | Yes [ ]  No [ ]   |
| **Does this carer require information and advice from us?**  | Yes [ ]  No [ ]  Don’t Know [ ]   |
| **Name of carer or person cared for:** |  |
| **Relationship to Client:** |  |
| **Address:** |  |
| **Contact Number:** |  |
| **Email Address:** |  |

**Reason for Referral**

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| **If possible, please include the nature of the problem; triggers; time of onset and what you would like help with.**   |
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| **Have you had previous mental health problems and/or contact with mental health services?** Yes [ ]  No [ ]  If yes, please give details: |
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| **Do you feel there are significant risk issues to yourself or others?** Yes [ ]  No [ ]  If yes, please give details:**Our service does not provide emergency care. In the event of an emergency, you are advised to contact your GP, local crisis number, attend your nearest A&E Department or dial 999.** |
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| **Are you using alcohol?Are you using illicit substances?****Are you misusing prescribed medication?Do you smoke?** | Yes [ ] Yes [ ] Yes [ ] Yes [ ]  | No [ ] No [ ] No [ ] No [ ]  | Unknown [ ] Unknown [ ] Unknown [ ] Unknown [ ]  | If yes, please give basic details regarding substance used, amount and frequency: |
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| --- | --- | --- |
| **Is there a local package of crisis care in place?** (eg HBT involved) |  Yes [ ]  No [ ]   | If yes, please state which team and contact details |
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| **Current prescribed medication:** |  |
| **Do you have any children? Do they live with you?** | Yes [ ]  Yes [ ]   | No [ ] No [ ]  |
| **Do you have any physical health problems?** | Yes [ ]   | No [ ]  | If yes, please provide details: |
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| **Do you consider yourself to have a disability?**  | Yes [ ]   | No [ ]  | If yes, please provide details: |
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| **Do you have any accessibility needs (e.g., can’t climb stairs, use of crutches/ wheelchair etc.)?** | Yes [ ]   | No [ ]  | If yes, please provide details: |
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| **Any other information:** |
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| **Are there other services currently involved in your care (e.g., Primary Care NHS, Royal British Legion, Combat Stress, Walking with the Wounded)?** **Have you made a referral to anyone else?**  | Yes [ ]   | No [ ]  | If yes, please provide details: |
| **Service:**  |  | **Name of Professional:**  |  | **Contact:** |  |
| **Service:**  |  | **Name of Professional:**  |  | **Contact:** |  |
| **Service:**  |  | **Name of Professional:**  |  | **Contact:** |  |

**Please note that we cannot process any NHS professional referrals without a copy of the latest Patient Assessment and a recent (within 72 hrs) Risk Assessment.**

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| **A copy of the latest Patient Assessment attached**  | **Yes □ No □****If no, reason:** |
| **A copy of the Risk Assessment (Updated past 72 hrs attached)** | **Yes □ No □****If no, reason:** |