

**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**](mailto: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**](mailto: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:** |  | | | | |
|  |  | | | | |
| **Were you Deployed Operationally?** | Yes  No | If yes, please state each tour with approximate years: | | | |
|  | | | | | |

**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: | | | | |
|  | | | | |
| **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.** | | | | |
|  | | | | |
| **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: |
|  | | | |
| **Do you consider yourself to have a disability?** | Yes | No | If yes, please provide details: |
|  | | | |
| **Do you have any accessibility needs (e.g., can’t climb stairs, use of crutches/ wheelchair etc.)?** | Yes | No | If yes, please provide details: |
|  | | | |
| **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:** |