**Referral Form**

**Date of referral**: Click here to enter a date.

Patient consent for sharing of information between referrer +CIFT Yes [ ]  No [ ]

Service user aware of referral Yes ☐ No ☐

Previous Contact with Mental Health Services: Yes [ ]  No [ ]

**Referred by:** Click here to enter text. **GP NAME:** Click here to enter text.

**GP PRACTICE**: Click here to enter text.

**Name:** Click here to enter text.

**Profession/role:** Click here to enter text.

**Address:** Click here to enter text.

**Email:** Click here to enter text.

**Telephone Number:** Click here to enter text.

**Service User Demographics**

Name: Click here to enter text. Alias: Click here to enter text.

NHS No. Click here to enter text. Ethnicity: Choose an item.

DOB: Click here to enter a date. Language: Click here to enter text.

Address: Click here to enter text. Interpreter/Sign Language: Choose an item.

Post Code: Click here to enter text. Employment: Choose an item.

Email: Click here to enter text.

Telephone: Click here to enter text. Marital status: Click here to enter text.

Mobile number: Click here to enter text. Housing: Choose an item.

Consent to contact by mobile/email: Yes [ ]  No [ ]

Parental Responsibility: Yes [ ]  No [ ]

Other useful information: (Best method/time to contact, physical health impairments etc.):

Click here to enter text.

**Risks**

**Perceived or Reported Risk (Please select one or more):**

Choose an item.Choose an item.Choose an item.

**Safeguarding, vulnerable adult or child protection concerns:**

Click here to enter text.

 Yes [ ]  No [ ]

**Reason for Referral** (For advice, please call **020 3317 7300** during office hours and ask for Intake worker)

**ONE OF THE FOLLOWING MUST BE CHOSEN IN ORDER TO PROCESS THE REFERRAL:**

Click to choose an item

**Last consultation:**

Click here to enter text.

**Current Treatment and Medication:**

Click here to enter text.

**Previous Treatment and Medication:**

Click here to enter text.

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| --- | --- |
| **Additional information**

|  |
| --- |
| (**EMIS Summary for GPs**)HeightWeightBody Mass IndexBlood pressure ReadingCVD RiskPhysical ActivityLifestyle advice/counselling givenDiabetes Hypertension CVD COPD AsthmaBlood parametersSerum cholesterolGlucoseThyroidHb.A1C – Diabetic controlAlcohol consumptionAlcohol adviceSmoking historySmoking cessation advice givenDrug useCannabis Cocaine Heroin, E/MDMA OtherMain drug used |

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**Please return this form by email with any supporting documents to:**

**cim-tr.aat-referrals@nhs.net**