Leeds Mental Wellbeing Service Therapies

Professional Referral Form

Please complete all sections. If all sections are not completed the referral will be returned to the referrer or forwarded to the patient's GP if no return address has been provided.

Date of referral:

Patient's details	
Name:	**Title:**
DOB:	**NHS number:**
Patient's address: **Postcode:**	**GP:** **GP Surgery:** **Address:** **Postcode:**
Preferred telephone contact number:	**Can we leave a voicemail?** ☐ Yes ☐ No **Can we send a text?** ☐ Yes ☐ No
Patient's email address: *(if known and consent to being used)*	
Is the patient aware of the referral and consent to their information being used? ☐ (Mark X in box to the right to confirm) *LMWS privacy policy: https://www.leedscommunityhealthcare.nhs.uk/about-us-new/access-to-information/privacy-notice/*	
Gender identity: ☐ Male* ☐ Female* ☐ Non-binary ☐ Other ☐ Not disclosed **including transgender*	Is this the same as birth? ☐ Yes ☐ No
Ethnicity:	
Refugee/asylum status: ☐ Destitute Asylum Seeker ☐ Asylum Seeker ☐ Refugee ☐ Not applicable	
Interpreter required: ☐ Yes ☐ No	**If yes,** please specify language:
Special requirements: ☐ Yes ☐ No	**If yes,** please specify:
Initially we send appointment letters/emails in English. If this is unsuitable, please advise of the best way to contact your patient:	
Pregnant or been pregnant in the last 12 months?	☐ Yes ☐ No
Is the client's partner pregnant or been pregnant in the last 12 months?	☐ Yes ☐ No
Is the client a main caregiver of a child under 12 months old?	☐ Yes ☐ No

Referrer's details (if different to GP):

Name:	**Job title:** *(without acronyms)*
Address:	**Tel number:** **Secure email address:**

LMWS Therapies is not an immediate support service. If the patient needs immediate support, please refer them to the Single point of Access on 0800 183 1485

We do not treat serious mental illness (SMI). However, if somebody has an underlying **stable** SMI and a common mental health problem, we can offer treatment for their common mental health problem.

Mental health information:

Is the patient currently under the care of our Primary Care Mental Health Team (PCMH)? ☐ Yes ☐ No

Does the patient have an open referral with another mental health service? ☐ Yes ☐ No

If yes, please indicate which team:

☐ Community Mental Health Team (CMHT) ☐ Crisis ☐ Forward Leeds ☐ Connect

Other mental health service *(please specify):*

Does the patient have a diagnosis of any of the below:

☐ Bipolar ☐ Personality disorder ☐ Schizophrenia ☐ Eating Disorder ☐ Schizoaffective disorder

If the patient has a diagnosis of any of the above, please answer the 4 questions below:

Have they been in secondary care services in the past 12 months? ☐ Yes ☐ No

If prescribed any psychotropic medication, please specify: ☐ Yes ☐ No

If yes, have they had any changes with this medication in the past 12 months? ☐ Yes ☐ No

Have there been any active symptoms or changes to their SMI in the last 12 months? ☐ Yes ☐ No

LMWS Therapies provide evidence-based structured treatments for common mental health problems such as anxiety disorders and depression

PLEASE NOTE: During review of this referral, if it is identified that our Primary Care Mental Health Team (PCMH) may be more appropriate to meet this client's needs, this referral will be redirected to PCMH.

Common mental health problem the patient wishes to address in treatment: *(please select)*

☐ **Depression**	☐ **Anxiety**	☐ **Social Anxiety**
☐ **Health Anxiety**	☐ **Obsessive Compulsive Disorder**	☐ **Panic**
☐ **Stress**	☐ **Low self esteem**	☐ **Post-traumatic stress disorder**

Other *(please specify below)*

Please provide a brief reason for recommending this patient for therapy:

Safety and risk information:

Risk factors *(please select)*	**If YES, please provide below details:** *Current thoughts, plans, intent, frequency, and any relevant historical risk information. Please include a safety plan if one has been completed.* *Current or historic risk from or to others, including any safeguarding concerns and how these are being managed (i.e. domestic violence services, MARAC).* *Quantity and frequency of alcohol and substance use and support in place for this.*
Suicide ☐ Yes ☐ No	
Harm to self ☐ Yes ☐ No	
Harm to others ☐ Yes ☐ No	
Self-neglect ☐ Yes ☐ No	
Risk from others ☐ Yes ☐ No	
Alcohol and substance use ☐ Yes ☐ No	

Please email the completed form to leeds.mws@nhs.net

If you have any queries about the referral process, contact the service on **0113 843 4388** or visit our website **www.leedsmentalwellbeingservice.co.uk**

Leeds Mental Wellbeing Service is a partnership between:

Leeds Community Healthcare NHS Trust, Leeds and York Partnership NHS Foundation Trust, Leeds GP Confederation, Northpoint Wellbeing, Community Links, Touchstone, Women's Counselling and Therapy Service, Homestart Leeds, Ieso Digital Health, SilverCloud Health, SignHealth

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