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**LEEDS MENTAL WELLBEING SERVICE**

**Recommendation Form Tel: 0113-8434388**

**Website: www.leedsmentalwellbeingservice.co.uk**

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**Please complete both pages** including the risk information. If all sections are not completed the referral will be returned to the referrer or forwarded to the person’s GP if no return address has been provided.

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| **Date of referral:** | | | | | | | | | |
| **Patients Details** | | | | | | | | | |
| **Name:** | | | | | | **Title:** | | | |
| **DOB:** | | | | | | **NHS Number:** | | | |
| **Patients Address:**  **Post Code:** | | | | | | **GP:**  **GP Surgery:**  **Address:**  **Post Code:** | | | |
| **Preferred Telephone Contact Number:** | | | | | | **Can we leave a message? YES /NO** | | | |
| **Ethnicity:** | | | | | | | | | |
| **Refugee/Asylum Status:** Destitute Asylum Seeker / Asylum Seeker / Refugee / None of the above *(please select)* | | | | | | | | | |
| **Interpreter Required: Y / N** | | | | **If yes please specify language:** | | | | | |
| **Special Requirements: Y / N** | | | | **If yes please specify:** | | | | | |
| **Is the client currently pregnant, or been pregnant/have a partner who has been pregnant in the last 12 months? Or alternatively, is the main caregiver of a child under 12 months?**  **The four options are, please indicate which is applicable**   * **Yes, pregnant or been pregnant** * **Yes, partner** * **Yes, main caregiver** * **No** | | | | | | | | | |
| **Referrers Details (if different to GP):** | | | | | | | | | |
| **Name:** | | | | | | **Designation:** | | | |
| **Address:**  **Post Code:** | | | | | | **Tel number:**  **Secure email address:** | | | |
| **At the moment is the client being seen by anyone else or receiving support from anyone else?** | | | | | | | | | |
| **Common Mental Health problem the person is presenting with:** *(please select)* | | | | | | | | |
| Depression | Anxiety | | | | Social Anxiety | | Health Anxiety | Obsessive Compulsive Disorder | |
| Panic | Stress | | | | Low self esteem | | Post-traumatic stress disorder | Other: *(please specify* | |
| **Please provide a brief reason for recommending:** | | | | | | | | |
| **Leeds Mental Wellbeing Service is not an immediate support service. If you feel this person needs immediate support, please refer them to the Single point of Access on 0300 300 1485.** | | | | | | | | |
| **Risk Factors** | | **Yes/No** | **If YES, please provide details. Include information on current thoughts, plans or intent and any past history.** | | | | | |
| Suicide | |  |  | | | | | |
| Harm to self | |  |  | | | | | |
| Harm to others | |  |  | | | | | |
| Self-neglect | |  |  | | | | | |

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