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**LEEDS MENTAL WELLBEING SERVICE – Therapy (Step 2/3)**

**Professionals Recommendation Form**

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**Please complete all sections** 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:** |  |  |  |  | **GP:** |
|  |  |  |  |  |  | **GP Surgery:** |
|  |  |  |  |  |  | **Address:** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Post Code:** |  |  |  |  | **Post Code:** |
| **Preferred Telephone Contact Number:** | **Can we leave a message? Yes / No** |
| **Patients email address:**  |  |
| ***(if known and consent to being used)*** |
| **Please tick to indicate that the patient is aware of the referral and consent to their information being used?** **(The Privacy Notice and information about how we use patient data can be found in the “What We Do With Your Information” section on** **https://www.leedscommunityhealthcare.nhs.uk/our-services-a-z/leeds-mental-wellbeing-service/what-we-offer/)** | [ ]  |
| **Ethnicity:** |  |
| **Refugee/Asylum Status:** | **Asylum Seeker / Refugee / Not applicable**   |
| **(Please circle which applies)** |
| **Interpreter Required:**  | **Yes / No** | **If yes please specify language:** |
| **Special Requirements:**  | **Yes / No** | **If Yes please specify:** |
| **Initially we send letters/email in English when offering appointments.** If there is a reason this is not suitable please advise of the best way to contact your patient: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Are they Pregnant or been pregnant in the last 12 months?** | **Yes / No** |
| **Are they a partner of someone who is pregnant or been pregnant in the last 12 months?** | **Yes / No** |
| **Are they the main caregiver of a child under 1?** | **Yes / No** |
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| **Referrers Details (if different to GP):** |
| **Name:** | **Designation:** |
| **Address:** | **Tel number:** |
|  |  |
|  | **Secure email address:**  |
| **Post Code:** |   |

**LMWS Therapies provide evidence-based treatment for common mental health problems such as anxiety disorders and depression.** 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. Please provide all mental health information below on any mental health diagnoses, service input, medication, safety, and the common mental health problem the patient wishes to address through therapy.

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| **Common Mental Health problem the person is presenting with for therapy:** *(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 this person for therapy:** |
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| **Mental health information** |
| **Is the patient currently receiving support from anyone else or has a current open referral with another mental health service?**  | **Yes / No** |
| **If yes, please indicate which team:** |
| **Primary care ( ) Community Mental Health Team ( ) Criss ( ) Forward Leeds ( ) Connect ( )** |
| **Other service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Does this person have a diagnosis of any of the below: (If yes please indicate which)** |
| **Bipolar ( ) Personality Disorder ( ) Schizophrenia ( ) Eating Disorder ( )**  |
| **Schizoaffective disorder ( )**  |
| **If this person has a diagnosis of any of the above please answer the below 4 questions:** |
| **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** |

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 0800 183 1485

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| **Safety and Risk Information** |
| **Risk Factors** | **Please indicate** | **If YES, please provide details. Include information on current thoughts, plans, intent, and frequency. Also any past history.** |
| Suicide | **Yes / No** |  |
|
| Harm to self | **Yes / No** |  |
|
| Harm to others | **Yes / No** |  |
|
| Self-neglect | **Yes / No** |  |
|

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

If you have any queries about referring or a current referral, please contact the service on 0113 8434388 or visit our website [www.leedsmentalwellbeingservice.co.uk](http://www.leedsmentalwellbeingservice.co.uk)