THE DEAF HEALTH CHARITY SIGNHEALTH BSL HEALTHY MINDS

Referral Form

Referral Date			
Title		NHS Number	
First Name		Date of Birth	
Surname		Gender	
Home Address			
Email	Fax	Mobile SMS	

Communication	BSL	☐	SSE	☐	Other ☐
	Lip reader	☐	Oral	☐	Deaf-blind ☐
Understand written English?	Yes	☐	No	☐	Not sure ☐
Deaf relay required?	Yes	☐	No	☐	

Referred by:	Self	GP
	Social Worker contact name and address	Other contact name and address
GP Name	Electronic Signature:	
Address: Contact number:		
Surgery Stamp		
Clinical Commissioning Group		
Contact details		

Long Term Condition : Asthma ☐ Cancer ☐ Chronic Pain ☐ Dementia ☐ Diabetes ☐
Epilepsy ☐ Heart Failure ☐ Or Medically Unexplained Conditions ☐ (please tick)

Ethnicity	Please tick below:		
White ☐	British ☐	Irish ☐	Other White Background ☐
Mixed ☐	White & Black Caribbean ☐	White & Asian ☐	Any other mixed background ☐
	White & Black African ☐		
Asian or Asian British ☐	Indian ☐	Pakistani ☐	Bangladeshi ☐
	Any other Asian background ☐		
Black British ☐	Caribbean ☐	African ☐	Any other Black background ☐
Other ethnic groups ☐	Chinese ☐	Any other ethnic group/ Not Stated ☐	
Religion			

Relationship Status	Single ☐	Married ☐	Co-habiting ☐
	Divorced ☐	Widowed ☐	Separated ☐
	Long term relationship ☐	Civil Partnership ☐	Not stated ☐
Any Children	Yes ☐	No ☐	How many:

Employment Status		
Employed – full or part time ☐	Unemployed ☐	Student ☐
Employed but currently off sick ☐	On disability benefit ☐	Retired ☐
Next of Kin		
Name		
Address Tel:		

Presenting Problem - What is the main problem?

Please tick any additional problems:

Agoraphobia (with or without panic) ☐	Anger ☐	Body dysmorphic disorder ☐	Carer issue ☐	Complex bereavement ☐
Coping with illness/chronic condition ☐	Depression ☐	Distress from work-related issue ☐	Eating disorder ☐	Generalised anxiety disorder (GAD) ☐
Health anxiety ☐	Medically unexplained symptoms ☐	Mild/occasional substance misuse ☐	Mixed anxiety & depressive disorder ☐	Obsessive compulsive disorder (OCD) ☐
Panic disorder ☐	Post-traumatic stress disorder ☐	Psychological distress linked to life event/life change ☐	Recurrent depressive disorder ☐	Relationship/family problems ☐
Sexual Issue ☐	Sexual/physical abuse issue ☐	Social Phobia symptoms ☐	Specific phobi ☐	Self-image/self esteem ☐

Details of any RISK issues including neglect, violence and vulnerability:

Previous history of counselling, psychological therapies or any other mental health services? If yes, please give details including dates and when discharged:

Currently involved with any other counselling, psychological therapy or mental health services? If yes, please give details:

Medication? If so, please give details

Please return to: BSL Healthy Minds, SignHealth, 5 Baring Road, Beaconsfield, Bucks. HP9 2NB

Or Email to: info@bslhealthyminds.org.uk Fax: 01494 687622