South London and Maudsley NHS
NHS Foundation Trust

IAPT Lewisham: Primary Care Psychological Therapies Service
Self-Referral Form

Todays date:

Your Name:		**Date of birth:**
Your Address:		
Telephone numbers you can be contacted on:		
1.	**Can a message be left?**	☐**Y** ☐**N**
2.	**Can a message be left?**	☐**Y** ☐ **N**
3. Can we send text message appointment reminders to your mobile phone?		☐**Y** ☐ **N**
Name and address of your GP Practice:	**Your GP's name and telephone no:**	

Please answer the following questions to help us think about how best to help you. *Please attach an extra page if you need more space.*

1. What are the main problems that have led you to ask for help (e.g. low mood, panic attacks, shyness, worrying etc)?

2. How long have you had these problems? (e.g. weeks, months, years?)

3. Are you currently seeing anyone for counselling / psychotherapy, drug or alcohol problems or for any other mental health support? ☐ **Yes** ☐ **No**

If **Yes**, please give details of where and for how long you are seeing them:

4. Have you seen anyone in the past for counselling / psychotherapy or because of drug or alcohol problems or had any contact with other mental health services ☐ **Yes** ☐ **No**
If **Yes**, when was that and what was it for?

5. Do you have any medical problems or are you on any medication at the moment? ☐**Yes** ☐ **No**
If **Yes,** please give details:

Please note this form can be completed electronically if you wish and emailed direct to the service, but please be aware we cannot guarantee secure encryption of your details sent to us via your personal email account.

<u>It is important that all the following questions are answered:</u>

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10	Feeling nervous, anxious or on edge	0	1	2	3
11	Not being able to stop or control worrying	0	1	2	3
12	Worrying too much about different things	0	1	2	3
13	Trouble relaxing	0	1	2	3
14	Being so restless that it is hard to sit still	0	1	2	3
15	Becoming easily annoyed or irritable	0	1	2	3
16	Feeling afraid as if something awful might happen	0	1	2	3

Patient Details: Name: DOB:
(This question is duplicated as we want to ensure all the papers for your referral are held together if faxed)

6. Please write here if there is anything else you think it is important for us to know?

7. If you have an idea of the type of help you would like to receive (e.g. computerised cognitive behaviour therapy (cCBT), cognitive behaviour therapy, counselling, couple therapy, group therapy, guided self-help or employment advice) please let us know here and we will do our best to take your wishes into account:

8. We would like to know more about you…………

NHS number (if known):

Patient Details: Name: DOB:

Gender: M☐ F ☐ NHS Number:

Do you have any special needs which we need to know about? (E.g. a disability, a physical health problem etc):

Long Term Conditions (Please tick relevant LTCs)

☐ Asthma ☐Cancer ☐ Chronic Pain ☐ Dementia
☐ Epilepsy ☐ Heart Failure ☐ Medically Unexplained conditions
☐ Coronary Heart Disease (CHD) ☐Chronic Obstructive Pulmonary Disease (COPD)
☐ Non Insulin Dependent Diabetes Mellitus (NIDDM)
☐ Insulin Dependent Diabetes Mellitus (IDDM)
☐ Chronic Muscular Skeletal
☐ Other – please state:

Main Language Spoken: Interpreter required? ☐**Yes** ☐ **No**

Ethnicity:

Please tick the box which best describes your sexual orientation
Heterosexual ☐ Lesbian /Gay ☐ Bi-sexual ☐ Other ☐ Prefer not to state ☐

Religion, how do you describe your faith? _____
(e.g. Christian, Muslim, Jewish etc)

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IAPT Lewisham Enquiries: 020 3228 1350 Fax: 020 8691 3237 Website: www.slam-iapt.nhs.uk

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Disability: Do you consider that you have a disability? **Yes** / **No**

If yes, please tick below the category that best describes your disability:

☐ Behaviour & Emotional	☐ Manual Dexterity	☐ Hearing
☐ Memory or ability to concentrate, learn or understand (Learning Disability)	☐ Mobility & Gross Motor	☐ Sight
☐Perception of Physical Danger	☐Personal, Self-Care & Continence	☐ Speech
☐ Progressive Conditions & Physical Health (such as HIV, cancer, multiple sclerosis, fits etc)		
☐ Prefer not to state (Person asked but declined to answer)	☐ No Perceived Disability	☐ Other

Please indicate which of the following options best describes your current status:

☐	Employed full-time (30 hours or more per week)	☐	Full-time homemaker with dependent children
☐	Employed part-time	☐	Full-time homemaker with no dependent children
☐	Self employed	☐	Carer
☐	Unemployed	☐	Voluntary work
☐	Full time student	☐	Work experience
☐	Full-time homemaker or carer	☐	Retired

Are you currently receiving Sick Pay (Statutory or other)? ☐**Yes** ☐**No** ☐ **Don't know**

Are you currently receiving Employment and Support Allowance Job Seekers Allowance, Income support or Incapacity benefit? ☐**Yes** ☐**No** ☐ **Don't know**

Would you like to talk to an employment support worker? ☐**Yes** ☐**No**

Lastly, please let us know how you heard about this service?

Please return this form to us in one of the following ways:

Fax: 020 8691 3237

Email: slm-tr.IAPTLewisham@nhs.net

Post: IAPT Lewisham, PO Box 73883, London, SE8 9EA

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