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| --- | --- | --- | --- |
| **Date** |  | **Is the patient consenting to this referral to SPA?**  | *Y/N**We are unable to accept referrals without patient consent*  |
| **Referral Source** | **Self-referral eg. Telephone**  | **Other: CTT, IRS, GP etc** | ***Please attach a copy of the original paper/email referral with this form to SPWS SPA.******Copy attached? Y/N***  |
| **Name** |  | ***DoB***  |  |
| **Address** |  | ***Email (if possible)*** |  |
| **NHS Number****(If Possible)** |  |
| **GP Practice** |  |
| **Landline** | **Can we leave voicemail? Y/N** | **Mobile**  | ***Can we leave voicemail? Y/N*** |
| **Nationality**  |  |
| **Ethnicity**  |  |
| **Religion** **(If possible)** |  |
| **Reason for referral** | ***Depression/low mood Addiction*** ***Anxiety  Trauma or abuse*** ***Relationship Issues  Bereavement***  |
| **Additional Information including any identified risk or complexity, any previous intervention?** |  |