|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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?** |  | | | | | |