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| **About this Form** |
| **This form should be used to refer patients aged at least 16 years old.**  **Referral forms can be securely emailed to** [**vitahealthgroup.refer.bb@nhs.net**](mailto:vitahealthgroup.refer.bb@nhs.net) **or (**[**self**](https://gateway.mayden.co.uk/referral-v2/0928eaf2-38d6-4a3c-ad7e-aeea81be22ba) **&** [**assisted forms**](https://gateway.mayden.co.uk/referral-v2/f0dc6cbf-76a7-446d-9abd-2e702d5c4ac0) **available online).** |

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| **Patient Consent** | |
| By submitting this form, you confirm that the patient has given consent for this referral, and you have informed the patient about how their information will be used except where a best interest decision has been made. Please select from the dropdown list below: | |
| I confirm that: | Choose an item. |

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| **Patient Information** | | | | | | | | | | | | | | | | | | | | | |
| Title: | Choose an item. | | | | First Name: | | |  | | | | | | Surname: | | |  | | | | |
| NHS Number: | |  | | | | | DOB: | | |  | | | | | Gender: | | | | Choose an item. | | |
| Address: |  | | | | | | | | Contact Information: | | | | | | | Consent to: | | | | |  |
| Email: | |  | | | | | Send emails? | | | | | ☐ Yes / ☐ No |
| Home: | |  | | | | | Leave voicemail? | | | | | ☐ Yes / ☐ No |
| Mobile: | |  | | | | | Leave voicemail? | | | | | ☐ Yes / ☐ No |
| Send SMS? | | | | | ☐ Yes / ☐ No |
|  | Preferred language (English) ☐ Yes / ☐ No | | | | | | | | | | | | |
| Disability: (please tick if appropriate) | | | | | | | | | | | | | | | | | | | | | |
| ☐ Visual | | | ☐ Speech | | | ☐ Learning | | | | | | ☐ Mobility | | | ☐ Other: | | |  | | | |
| ☐ Peri-Natal | | | | ☐ Military Veteran | | | | | | | Ethnicity: | | Choose an item. | | | | | | |  | |

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| **Referrer and GP Information** | | | | | | | |
| Referring Service: | Choose an item. | If other, please state: | | |  | | |
| Name of Referrer: |  | | Contact Telephone: | | | |  |
| Date of Referral: |  | | Contact Email: | | | |  |
| GP Practice: |  | | | GP Name: | |  | |

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| **Referral Background** | | | | |
| **Reason for referral, including any screening questionnaire scores:** | | | | |
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| **Mental health history; current or past risk to self or others; safeguarding issues (if applicable):** | | | | |
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| **Long-Term Condition and Bespoke Long-Term Condition Course that the patient is being referred for:** | | | | |
| ☐ | Type 1 Diabetes | | ☐ | Living Well with Diabetes course |
| ☐ | Type 2 Diabetes | | ☐ | Living Well with Diabetes course |
| ☐ | Cardiovascular condition | | ☐ | Living Well with Cardiovascular Conditions course |
| ☐ | Chronic Obstructive Pulmonary Disease | | ☐ | Living Well with Respiratory Conditions course |
| ☐ | Long COVID | | ☐ | Living Well with Respiratory Conditions course |
| ☐ | Asthma | | ☐ | Living Well with Respiratory Conditions course |
| ☐ | Musculoskeletal Pain | | ☐ | Living Well with Pain course |
| ☐ | Irritable Bowel Syndrome (IBS) | | ☐ | Living Well with IBS course |
| ☐ | Other LTC (please state: ) | | ☐ | Generic LTC course |
|  | |  | | |
| Main mental health concern | | ☐ Depression  ☐ Anxiety | | |