**Self-Referral Form**

We accept referrals from clients who are aged 16 years and over and registered with a GP in Hertfordshire.

**Demographic Information**

First, we would like to know a little bit about you…

|  |  |  |  |
| --- | --- | --- | --- |
| First Name: |  | | |
| Surname: |  | | |
| Date of Birth (dd/mm/yyyy): | | | / / |
| Gender (please circle): | | Male / Female | |

|  |  |
| --- | --- |
| Address: |  |
| Postcode: |  |

|  |  |
| --- | --- |
| Landline number: |  |
| Can voicemail messages be left on your landline (please circle): | Yes / No |

|  |  |
| --- | --- |
| Mobile number: |  |
| Can voicemail messages be left on your mobile (please circle): | Yes / No |

|  |  |
| --- | --- |
| Your GP’s name: |  |
| Name and address of your surgery: |  |
| Is your GP aware of your self-referral (please circle)? | Yes / No |

|  |  |  |
| --- | --- | --- |
| Your ethnicity (please tick) | | |
| * White British * White Irish * Any other white | * Mixed: White & Black Caribbean * Mixed: White & Black African * Mixed: White & Asian * Any other mixed background | * Asian or Asian British: Pakistani * Asian or Asian British: Bangladeshi * Asian or Asian British: Indian * Asian or Asian British: Any other background |
| * Chinese | * Other (please state): | * I do not wish to state |

**Current Difficulties**

|  |
| --- |
| Please describe the problem you would like help with: |
|  |

|  |
| --- |
| How long have you had this problem (e.g. weeks, months, years)? |
|  |

|  |  |  |
| --- | --- | --- |
| Have you received, or are you currently receiving, treatment for this problem (please circle)? | | Yes / No |
| If yes, please give details (e.g. what, when and for how long): | | |
|  | | |
| Are you currently taking any medication (please circle)? | Yes / No | |
| If yes, please give details: | | |
|  | | |

|  |  |  |
| --- | --- | --- |
| Are there any issues with alcohol or recreational drugs? | | |
| Alcohol (please circle): | | Yes / No |
| Drugs (please circle): | | Yes / No |
| If yes, please specify: |  | |

**Assessing Risk**

|  |  |  |
| --- | --- | --- |
| Do you currently feel you are a risk to yourself (please circle)? | | Yes / No |
| Do you currently feel you are a risk to others (please circle)? | | Yes / No |
| Do you currently feel you are at risk **from** others (please circle)? | | Yes / No |
| If yes, please give details: |  | |

|  |  |  |
| --- | --- | --- |
| Are your family and friends concerned about any of your behaviours (please circle)? | | Yes / No |
| If yes, please give details: |  | |

|  |
| --- |
| Please let us know what you are hoping to gain from our service: |
|  |

Thank you for taking the time to complete this form. A member of our team will contact you after receiving the form, in order to arrange an appointment for you to be seen within 28 days.

Please return this form to the following address:

Freepost RTHZ-XTSC-BXKC

The Single Point of Access,

Wellbeing Service Referral,

Hertfordshire Partnership University NHS Foundation Trust

99 Waverley Road

St Albans

AL3 5TL

Or e-mail it to: [spafastrack@HPFT.nhs.uk](mailto:spafastrack@HPFT.nhs.uk)

Please note that unless you are sending the email from an encrypted system, this method of communication may not be secure. If you have any concerns about emailing it back to us, please post to the above address.

**Please note: Our service is not able to provide immediate support in an emergency. If you require immediate urgent help, please contact the Single Point of Access (SPA) service on: 0300 777 0707**

**October 2013**