**LONGTERM HEALTH CONDITIONS PROJECT CROYDON**

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| **Full Name of Patient:** Click here to enter text.  **Address:** Click here to enter text.    **Postcode:** Click here to enter text. | | | **Date of birth** Click here to enter text. | |
| **NHS number** Click here to enter text. | |
| **Phone number** Can a message be left?  Yes No  Home Click here to enter text.  MOBILE Click here to enter text.  Email address: Click here to enter text. | |
| **LONGTERM CONDITION(S): e.g. DIABETES, C.O.P.D., CORONARY HEART DISEASE/HEART FAILURE, IBS, CHRONIC FATIGUE, CHRONIC PAIN, CHRONIC SKIN DISEASE, CHRONIC RENAL FAILURE, MS, PARKINSONS,STROKE, MILD DEMENTIA.**  Click here to enter text.  **Please state if any special needs or requirements:**  (e.g. disability/mobility problems; literacy difficulties; needs an interpreter)  Click here to enter text.  If an interpreter is required, please state which language: Click here to enter text. | | | | |
| **Referrer details: Name and address, email address, telephone number:**  Click here to enter text. | | **GP’s name and address (if different)**  Click here to enter text. | | |
| **Date of referral:** Click here to enter text. | |
| **Reason for referral:** Click here to enter text.  Please **tick** the patients presenting psychological problems below. | | | | |
| Panic disorder |  | Depressive episode/low mood | |  |
| Agoraphobia (with or without panic disorder) |  | Obsessive Compulsive Disorder | |  |
| Social Anxiety |  | Specific Phobia | |  |
| Post Traumatic Stress Disorder |  | Recurrent depressive disorder | |  |
| Health Anxiety |  | Generalized Anxiety Disorder | |  |
| **Any other information that it would be useful for us to know?** (E.g. risk issues, planned surgery/medical treatment, compliance with medical regimen, over or under use of prescribed medication, social or housing factors, or any significant family issues/bereavements).  Click here to enter text.  **Please answer the following questions: (YES/NO)**  **Is the patient aged over 18?** YES NO  **Is the patient resident in Croydon/ registered with a Croydon GP?** YES NO  **Does the patient have a problem with alcohol, or other substance use, that could interfere with therapy?** YES NO  **Does the patient have severe/enduring mental health problems which require input from secondary mental health services (e.g. schizophrenia, identified personality disorder?)** YES NO  **Is the patient motivated to work on issues i.e. actively participate in therapy? (The service offers Cognitive Behavioural therapies and Mindfullness Based Cognitive Therapy *not* Counselling)** YES NO  **If possible, please ask the patient the following questions before referral:**  **Over the last 2 weeks: How often have you been bothered by the following problems?**  **Little interest or pleasure in doing things?** Choose an item.  (Not at all, Several days, More than half the days, Nearly every day).  **Feeling down, depressed or hopeless? Choose an item.**  (Not at all, Several days, More than half the days, Nearly every day).  **Feeling nervous, anxious or on edge?** Choose an item.  (Not at all, Several days, More than half the days, Nearly every day).  **Not being able to stop or control worrying?** Choose an item.  (Not at all, Several days, More than half the days, Nearly every day)  **\*\*For diabetes referrals: latest HBA1c score and date of test:**  Click here to enter text.  **Any other measures recently completed (e.g. HADS/CRDQ/MMSE).**  Click here to enter text.  Please send by post to: **Croydon IAPT: Psychological Therapies and Wellbeing Service**  Wickham Park House, Bethlem Royal Hospital, Monks Orchard Road, Beckenham, Kent, BR3 3BX Telephone: 0203 228 4040/4038  **Or**  **Email: croydoniapt@slam.nhs.uk**  **Fax: 0203 228 2955** | | | | |