**LONGTERM HEALTH CONDITIONS PROJECT CROYDON**

|  |  |
| --- | --- |
| **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 NoHome 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** |