

# MIND IN BEXLEY IAPT SERVICE

[www.mindinbexley.org.uk](http://www.mindinbexley.org.uk)

## THIS FORM IS FOR SELF REFERRALS and ASSISTED SELF REFERRALS ONLY. ALL SECTIONS MUST BE COMPLETED

An assisted self referral is where you are helped to refer yourself to the service by someone who is not a Health Professional e.g. an Adviser at Job Centre Plus, Personnel Adviser or Manager at your place of work, your Parish Priest. etc.

Your name	<input type="text"/>	DATE OF BIRTH	<input type="text"/>
Address and Postcode	<input type="text"/>	GENDER	<input type="checkbox"/> Male <input type="checkbox"/> Female
		NHS Number *	<input type="text"/>
Landline Phone	<input type="text"/>	Additional Needs (language, sensory, mobile etc)	<input type="text"/>
Can we leave a message for you on this phone	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Mobile Phone	<input type="text"/>	Email	<input type="text"/>
Can we leave a message for you on this phone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Can we contact you via email?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Ethnicity</b>	<input type="checkbox"/> White <input type="checkbox"/> Mixed Ethnicity <input type="checkbox"/> Asian / Asian British <input type="checkbox"/> Black / Black British <input type="checkbox"/> Other <input type="checkbox"/> Not Stated		

### DETAIL OF PERSON ASSISTING YOU (if applicable)

Assister's name	<input type="text"/>	Job / Role	<input type="text"/>
Address and Postcode	<input type="text"/>	Working hours	<input type="text"/>
		Signature	<input type="text"/>
Landline Phone	<input type="text"/>	<b>Would you like your Assister to be kept informed about your referral and your progress.</b>	
Mobile Phone	<input type="text"/>	<input type="checkbox"/> Yes, please keep my Assister informed <input type="checkbox"/> No, I only want their help completing the form	

**In order to be eligible for the service you must be registered with a GP in the Bexley Borough. Your GP will be informed if we have any concerns. By agreeing to receive this service you are consenting to us informing your GP if we have any concerns.**

**Please give us the name of your GP and the surgery details**

GP NAME	<input type="text"/>	Surgery	<input type="text"/>
Address and Postcode	<input type="text"/>	Phone	<input type="text"/>

\* This can be found on letters from your GP or hospital

# Please answer the following questions

## Psychological/social support needs- Please tick all the boxes that you think you need support for or help with

- Panic Disorder     Obsessive Compulsive Disorder (OCD)     Post Traumatic Stress Disorder (PTSD)     Depression
- Employment     Health/Lifestyle     General Anxiety Disorder (GAD)     Leisure/Social
- Social Phobia     Financial/Benefits/Debts     Long term health condition

Please tell us briefly why you are referring yourself to Being Well in Bexley

If you are taking any medication for your mental health please tell us what you are taking

## Over the last 2 weeks how often have you been bothered by any of the following problems?

- |   |                                     |                                       |  |   |
|---|-------------------------------------|---------------------------------------|--|---|
| Little interest or pleasure in doing things   | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than half the days | <input type="checkbox"/> Nearly every day |
| Feeling down, depressed, or hopeless  | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than half the days | <input type="checkbox"/> Nearly every day |
| Trouble falling or staying asleep, or sleeping too much   | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than half the days | <input type="checkbox"/> Nearly every day |
| Feeling tired or having little energy   | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than half the days | <input type="checkbox"/> Nearly every day |
| Poor appetite or overeating   | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than half the days | <input type="checkbox"/> Nearly every day |
| Feeling bad about yourself -- or that you are a failure or have let yourself or your family down  | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than half the days | <input type="checkbox"/> Nearly every day |
| Trouble concentrating on things, such as reading the newspaper or watching television   | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than half the days | <input type="checkbox"/> Nearly every day |
| Moving or speaking so slowly that other people could have noticed? Or the opposite -- being so fidgety or restless that you have been moving around a lot more than usual | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than half the days | <input type="checkbox"/> Nearly every day |
| Thoughts that you would be better off dead or of hurting yourself in some way   | <input type="checkbox"/> Not at all | <input type="checkbox"/> Several Days | <input type="checkbox"/> More than half the days | <input type="checkbox"/> Nearly every day |

**Over the last 2 weeks how often have you been bothered by any of the following problems?**

- Feeling nervous, anxious or on edge  Not at all  Several Days  More than half the days  Nearly every day
- Not being able to stop or control worrying  Not at all  Several Days  More than half the days  Nearly every day
- Worrying too much about different things  Not at all  Several Days  More than half the days  Nearly every day
- Trouble relaxing  Not at all  Several Days  More than half the days  Nearly every day
- Being so restless that it is hard to sit still  Not at all  Several Days  More than half the days  Nearly every day
- Becoming easily annoyed or irritable  Not at all  Several Days  More than half the days  Nearly every day
- Feeling afraid as if something awful might happen  Not at all  Several Days  More than half the days  Nearly every day

**Choose a number from the scale below to show how much you would avoid each of the situations or objects listed below. Then write the number in the box opposite the situation.**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>
<b>Would not avoid it</b>		<b>Slightly avoid it</b>		<b>Definitely avoid it</b>		<b>Markedly avoid it</b>		<b>Always Avoid it</b>

- Social situations due to a fear of being embarrassed or making a fool of myself
- Certain situations because of a fear of having a panic attack or other distressing symptoms (such as loss of bladder control, vomiting or dizziness)
- Certain situations because of a fear of particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying).

Are you receiving another service  Yes  No

If, yes, specify which service

Preferred method of contact  Email  Letter  Phone

**Only fully completed referral forms will be accepted, so please go back and check that you have completed every section as fully and accurately as you can, then sign and date it.**

**We will contact you within 14 working days of receiving your completed form and let you know whether or not we will be able to offer you an assessment for this service.**

Signed  Date

**This referral form may be posted to: IAPT Mind in Bexley, 240a Broadway Bexleyheath, Kent, DA6 8AS**

**E-mailed to: [referral@mindinbexley.org.uk](mailto:referral@mindinbexley.org.uk)**

**for office use only...**

Date received at Mindin Bexley

Date logged onto IAPTus

**Being Well in Bexley Self and Assisted Referral Form Version 2, September 2011.**

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