

Client / Patient name Landline

Mr Mrs Miss Ms Dr Other

Mobile

Full address Including Postcode:

Permission to leave a message Landline Mobile

DATE OF BIRTH

NHS Number :

Email:

Reason for referral

GENDER Male Female

Current relevant i.e. (Psychotropic) Medications:

Client preference Counselling CBT

Psychological/social support needs:

Depression GAD Panic Disorder Social Phobia PTSD OCD Employment Leisure/Social

LTC (Long term health Condition) Health/Lifestyle Financial/Benefits/Debt MUS (Medically unexplained symptoms)

Other

Does the client/patient have any additional needs?

Sensory Language Mobility

If yes to any of above, please specify

Risk History: (if yes please provide details)*

Yes No

Self Harm Harm to others Suicidal thoughts/intentions

Has the client/patient agreed to the referral?

Yes No

PHQ 9 Score GAD 9 Score

Phobia Scales Score

These are required to assist allocation to the correct intervention and must be completed and attached (we are unable to process without these documents)

*** this service is *not suitable* for patients with: active suicidal ideas; a current diagnosis of psychosis, personality disorder or organic mental disorder; alcohol and/or drug dependence**

GP/Professional name Surgery/direct number

Address and Postcode Email

Signature.....

DATE

This referral is for the Mind in Bexley Primary Care Level CBT and Counselling Service. Once referred, the patient will be assessed and given the most appropriate level of support (either Counselling, step 2 Guided Self-help CBT or step 3 one to one CBT).

PHQ 9

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

	Not at all	Several Days	More than half the days	Nearly every day
1 Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2 Feeling down, depressed or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3 Trouble falling, staying asleep or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4 Feeling tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5 Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6 Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7 Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8 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"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9 Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Total PHQ9 Score =

GAD 7

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

	Not at all	Several Days	More than half the days	Nearly every day
1 Feeling nervous, anxious or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2 Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3 Worrying too much about different things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4 Trouble relaxing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5 Being so restless that it is hard to sit still	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6 Becoming easily annoyed or irritable	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7 Feeling afraid as if something awful might happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Total GAD7 Score =

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.

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

A17 Social situations due to a fear of being embarrassed or making a fool of myself

A18 Certain situations because of a fear of having a panic attack or other distressing symptoms (such as loss of bladder control, vomiting or dizziness)

A19 Certain situations because of a fear of particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying).

IAPT EMPLOYMENT STATUS QUESTIONS

A14 - Please indicate which of the following options best describes your current status:

- Employed full-time (30 hours or more per week) Full-time student
- Employed part-time Retired
- Unemployed Full-time homemaker or carer

A15 - Are you currently receiving Statutory Sick Pay? YES NO

A16 - Are you currently receiving Job Seekers Allowance, Income support or Incapacity benefit? YES NO

Work and Social Adjustment

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity.

1. **WORK** -if you are retired or choose not to have a job for reasons unrelated to your problem, please tick N/A (not applicable) **Score**

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely - I cannot work

2. **HOME MANAGEMENT** - Cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc **Score**

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

3. **SOCIAL LEISURE ACTIVITIES** - With other people, e.g. parties, pubs, outings, entertaining etc. **Score**

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

4. **PRIVATE LEISURE ACTIVITIES** - Done alone, e.g. reading, gardening, sewing, hobbies, walking etc. **Score**

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

5. **FAMILY AND RELATIONSHIPS** - Form and maintain close relationships with others including the people that I live with **Score**

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

A13 - W&SAS total score

Are you taking medication for your anxiety and/or depression? YES NO