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### **Medical Referral Form**

<b>Patient Details</b>	
Name	
Address	
DoB	
Gender	
<b>Primary Medical Diagnosis</b>	
Current medical treatment	
Awaiting further assessment/specialist referral? <b>Please state Yes or No.</b> (If Yes, please provide details)	
Awaiting further medical treatment or surgical interventions? <b>Please state Yes or No.</b> (If Yes, please provide details)	
Is the patient currently, or intending to be, involved in litigation in relation to his/her primary diagnosis? <b>Please state Yes or No.</b>	
Co-morbid physical conditions	
Other Medications	
GP name	
GP address	
GP Telephone	

<b>Details of referring health professional</b>	
Name	
Position	
Address	
Telephone	
Email	
Fax:	
<p><b>Reasons for referral</b> (e.g. adjustment to diagnosis or treatment, self-management, low mood/high anxiety related to diagnosis, difficulties making or maintaining required lifestyle changes, need to reduce dependence on medical interventions, etc.)</p> <div style="text-align: center;">  <p>PSYCHOLOGY for Health</p> </div>	

Please note the following **general exclusions**:

- Patients under 18 years
- Patients being seen by another psychologist or by a counsellor
- Patients for whom severe or enduring mental health issues are the dominant concern
- Patients for whom drug or alcohol issues are the dominant concern
- Patients in crisis (e.g. acute risk of suicide)
- Patients with terminal illness
- Patients who have displayed aggressive behaviour which posed a risk to themselves or to others

Thank you for completing this form. Please send to:

Email: [dee.hunnie@nhs.net](mailto:dee.hunnie@nhs.net)

Tel: 01234 792000

Fax: 01234 795700

We will contact you after reading this referral