**Psychology Referral Form**

Thank you for enquiring about our Treating Psychology service.

**Please note our referral meetings are held twice a week.**

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| **Referrer Details** |
| Date of referral: |  |
| Referrer contact name: |  |
| Referrer contact email address: |  |
| Referrer contact phone number: |  |
| Service being sought: | ☐ Psychology Assessment only ☐ Psychology Assessment + Treatment |

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| **Client Details** |
| 1 | Client initials  |  |
| 2 | Client Location  |  |
| 3 | Client Age  |  |
| 4 | Gender  | ☐ Male ☐ Female ☐ Other |
| 5 | Client’s preferred languageClient’s ethnicity/cultural identity | (leave blank if English language is adequate/no non-white English cultural preferences) |
| 6 | Litigation Status | ☐ Settled ☐ Unsettled ☐ Deputy |
| 7 | Injury | ☐ Brain injury ☐ Spinal cord injury ☐ Orthopaedic injury |
| 8 | Preferred Method of Input  | ☐ Online ☐ Face-to-Face ☐ Hybrid (for example asst F2F and online for treatment) |
| 9 | Any current concerns or risks? | ☐ No☐ Yes - monitored risks (please state): ☐ Yes - social care involvement  |
| 10 | Any inter-agency or therapy involvement at present?  | ☐ No☐ Case Manager ☐ OT ☐ Physio ☐ Psychologist ☐ Care ☐ SLT ☐ School/Workplace ☐ NHS services ☐ Third sector ☐ Local Authority☐ Other (please state): |
| 11 | Please provide a brief detail of injury including month/yearPlease include how the client presents e.g. trauma, communication, mobility, cognitive impairment, emotions, behaviour, pain, fatigue etc |  |
| 11a | Psychological area of need  | ☐ Trauma/EMDR ☐ Neuropsychological support ☐ Learning Disability ☐ Pain ☐ Mental health e.g. anxiety, depression, adjustment, grief, loss☐ Challenging behaviours ☐ Eating disorders ☐ Family/systemic work ☐ Couples input ☐ Care team input/training ☐ Parenting support/training☐ Psychoeducation ☐ Consultancy to wider team including  schools/workplace☐ Cognitive assessment ☐ Mental Capacity Assessments |
| 11b | Please elaborate here on identified psychological area(s) of need, ideally with clinical questions/goals |  |
| 12 | Please provide any further relevant information that could contribute to a positive therapeutic relationship eg hobbies, interests, preferences etc |  |
| 13 | Who lives with the client? Please also state any animals in the client’s property |  |
| 14 | I would like to be kept up to date with service updates/blogs from PsychWorks Associates. You can unsubscribe at any time from within our update emails. | ☐ |
| 15 | Where did you hear about PsychWorks Associates? | ☐ Word of mouth ☐ Social media ☐ Training event☐ Conference material ☐ Worked with PWA before **If other please state:**  |

**Please return the completed form to** **admin@psychworks.org.uk**

Please note:

Assessments will usually take place at the most appropriate location for the client (normally the home address). Travel costs are based from Associates’ individual office locations.

In exceptional circumstances, PsychWorks Associates reserves the right to pause the assessment process if it is not deemed to be clinically appropriate at the current time. Full and thorough discussion would take place with the referrer prior to any such decision being made.

Pre-assessment ‘meet and greet’ sessions for engagement may be charged in addition to assessment cost, at the hourly rate plus Associates’ travel.

Any duty of care support that has arisen that was not anticipated e.g. safeguarding matters will also be charged at the hourly rates plus Associates’ travel.

Associate input will be available when agreement to funding has been provided, and signed terms of business are received from the commissioning parties.