**Psychology Referral Form**

Thank you for enquiring about our Treating Psychology service (non-expert).

**Please note our referral meetings are held weekly.**

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| **Referrer Details** | |
| Date of referral: |  |
| Referrer contact name: |  |
| Referrer contact email address: |  |
| Referrer contact phone number: |  |
| Non-expert 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 language  Client’s ethnicity/cultural identity | (leave blank if English language is adequate/no non-white English cultural preferences) |
| 6 | Litigation Status  Is funding already available for the assessment and treatment to commence within a month? | ☐ Settled ☐ Unsettled ☐ Deputy  ☐ Yes  ☐ No – if no, we might have to operate a waiting list |
| 7 | Injury | ☐ Brain injury ☐ Spinal cord injury ☐ Orthopaedic injury |
| 8 | Preferred Method of Input  (NB: online options may allow for quicker commencement | ☐ Online ☐ Face-to-Face  ☐ Hybrid (eg assessment/starting F2F and then moving to online) |
| 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): |
| 11a | Please provide a brief detail of injury including month/year  Please include how the client presents e.g. trauma, communication, mobility, cognitive impairment, emotions, behaviour, pain, fatigue etc |  |
| 11b | Psychological area of need | ☐ Trauma ☐ EMDR  ☐ Neuropsychological/brain injury 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 |
| 11c | 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. | ☐ yes please |
| 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**](mailto:admin@psychworks.org.uk?subject=Referral)

Please note:

We **do not** offer a medico-legal/expert witness service.

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.