**Oxford Health Specialist Psychological Intervention Centre**

**Clinic Referrals**

**Isis Education Centre**

**Warneford Hospital  
Oxford OX3 7JX**

**Clinic email:** ohspic@oxfordhealth.nhs.uk

**Web:** www.oxfordhealth.nhs.uk/ohspic

**Referral Form**

|  |  |
| --- | --- |
| **Name** |  |
| **Also/prefers to be known as** |  |
| **Preferred pronouns** |  |
| **Address** |  |
| **DOB** |  |
| **NHS Number** |  |
| **Ethnicity** |  |
| **Contact Phone number/s** |  |
| **Email address** |  |
| **First language** |  |
| **Interpreter required? Yes/No and details** |  |
| **Does the person have any communication needs?** |  |
| **Details of people living with the patient (name, relationship, and approx. age if a sibling)** |  |
| **Referrer Details** | |
| **Name & job title/profession** |  |
| **Address** |  |
| **Email** |  |
| **Telephone** |  |
| **Details of Care Coordinator / other professionals involved (name, job title, address, and phone number)** |  |
| **GP Details (if different from above i.e., where GP is not the referrer)** | |
| **Name and address** |  |
| **Telephone number** |  |
| **Email address** |  |

**Presenting Problem / Reason for Referral**

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| --- |
| **Brief description of the main problems** |
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| **Duration and significant changes over time** |
|  |
| **Impact on functioning** |
|  |
| **Hopes for treatment** |
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| --- |
| **Any recent significant life events/changes? E.g., bereavement, changes in significant relationships, transitions, etc.** |
|  |
| **Physical health, disabilities, learning difficulties, including medical history, significant injuries, etc. Please note any diagnoses previously given** |
|  |
| **Details of any current interventions / inpatient stays / medications that are underway to address the current problems, and current progress** |
|  |
| **Details of any previous interventions / inpatient stays / medication already undertaken to address the current problems, and outcomes** |
|  |

**If Patient is a child:**

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| --- | --- |
| **Parent / carers name, address and contact details** | |
| **Name (relationship)** |  |
| **Address and post code (if different from above)** |  |
| **Contact telephone number** |  |
| **Other significant carer/ family member(s)** |  |
| **Details of siblings (if not already listed above) including date of birth, and school and GP details if different from the referred person** | |
|  | |
| **Current Education Provider (We will not contact school unless parent/patient consent has been given)** | |
| **Name of School/College** |  |
| **Address** |  |
| **Telephone or contact details** |  |
| **If the referral relates to a child/young person, are they in the Looked After Children system?** | **Yes / No / Do not know** |
| **Child protection / Child in Need plan in place?** | **Yes / No / Do not know Category \_\_\_\_\_\_** |
| **Common Assessment Framework (CAF) completed?** | **Yes/No – If yes, please attach a copy to this referral** |
| **If CAF has not been completed, how did you come to this decision not to complete a CAF?** | |
|  | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT IS AT RISK OF…  (Tick as applicable)** | | | | | | | |
| **Physical abuse** |  | **Sexual abuse** |  | **Self-harm/ Suicide** |  | **Substance misuse** |  |
| **Emotional abuse** |  | **Neglect** |  | **Harm to others** |  | **Offending behaviour** |  |
| **Suicide** |  |  |  |  |  |  |  |
| **Please give further details e.g., suitability of home visits (incl. current risk management plan)** |  | | | | | | |
| **RISK to Clinicians (Please give details)** |  | | | | | | |
| **Are there any therapeutic reasons why the gender of the therapist is of any concern?** |  | | | | | | |

**I confirm that the patient has consented to making this referral and sharing their information:**

Yes  No

If no, please give details why not:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referrer name & occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of form completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please return this form to:** [ohspic@oxfordhealth.nhs.uk](mailto:ohspic@oxfordhealth.nhs.uk)