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*Occupational Health Department:*

*Tel: 01623 622515 Ext: 3780 or 3781*

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| **CONFIDENTIAL STAFF CLINICAL PSYCHOLOGY REFERRAL FORM**  **FOR REFERRAL TO THE STAFF CLINICAL PSYCHOLOGY SERVICE**  Please email this form once complete to: [sfh-tr.clinical-psychologists@nhs.net](mailto:sfh-tr.clinical-psychologists@nhs.net)  Please complete all sections. **Sections marked with an \* are mandatory and we will be unable to process your referral without this information.**  Confirmation of receipt of the referral will be sent to the individual referred and no communication will be made with the individual’s manager. | |
| **\*Full Name** |  |
| **\*Date of Birth** |  |
| **\*Ethnicity** |  |
| **\*Gender** |  |
| **\*Home Address & Post Code** |  |
| **\*Home or Mobile Telephone Number (whichever is preferable for contact)** |  |
| **\*Can an answerphone message be left? Please circle** | **Yes No** |
| **Work phone extension** |  |
| **\*Job Title** |  |
| **\*Work email** |  |
| **\*Personal email** |  |
| **Is this a first referral?**  **Is this a subsequent referral?** |  |
| **Reason for referral, e.g., work-related trauma, work-related stress, traumatic work-related incident, etc. Please give a brief summary of key concerns and issues to be addressed.**  **(if this is a subsequent referral please state why another referral has been made)** |  |
| **If the individual being referred is currently off sick, then please give the date of when the sickness absence started.** |  |
| **The Service is only accessible to staff who are not already in receipt of, or waiting for, psychological therapy, counselling, or mental health support via another service. Have you checked this is the case? Please circle accordingly.** | **Yes No** |
| **THIS SERVICE IS NOT APPROPRIATE FOR INDIVIDUALS REPORTING ACTIVE SUICIDAL IDEATION OR PLANNING AND OR DELIBERATE SELF HARM – PLEASE REFER TO CRISIS CONTACT NUMBERS IN THE ACCOMPANYING GUIDANCE LEAFLET FOR SUPPORT** | |

**If this is not a self-referral, the Referrer must inform the member of staff that a referral to the Staff Clinical Psychology Service has been made and the reason why. Where possible provide a copy of this completed form to the staff member prior to sending to the Staff Clinical Psychology Service.**

**I confirm that that the above has been undertaken:**

\***Referrer’s signature..................................................................................**Date………………………

|  |  |
| --- | --- |
| \***Referrer’s name** |  |
| \***Job title** |  |
| \***Department** |  |
| **Base/Directorate** |  |
| \***Email address** |  |
| **Telephone number** |  |

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| \***Employing Trust/Organisation** |  |