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| **Client Details:** |
| Forename: Surname: |
| Gender: Male/Female DOB/CHI: |
| Relationship Status:  Dependents (details): |
| Home address: Tel No:  Post code:  Does the client have digital access to engage with a video call? Y/N |
| Is the client homeless or at risk of homelessness? Yes/No/Not Known  Type of accommodation? (please circle as appropriate)  Hostel/B&B/emergency accommodation  No fixed abode/rough sleeping  Own tenancy  Temporary furnished flat  Destitute  Supported accommodation  Children’s Unit  National Asylum Support Service (NASS) |
| Ok to send correspondence to home address? Yes/No |
| Is the client an Asylum Seeker or refugee? Yes/No  Country of origin:  Asylum Status:  Asylum seeker  Refused Asylum seeker  Refugee  Destitute  Unaccompanied Asylum Seeker Child  Not Known |
| Interpreter required? Yes/No Language:  Preferred interpreter/gender if known: |
| Is the client a victim of trafficking? Yes/No/Not known  If yes provide details: |
| Does the client have a disability? Yes/No  Please Specify:  Details of disability requirements (e.g. wheelchair access required, communication aids): |
| Does the client belong to any of the following marginalised groups?  Gypsy/traveller  Ex-service personnel  Prisoner/Ex-offender  People involved in prostitution  People with literacy issues  In Care/Leaving Care/Care History |

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| **Registered GP Details** |
| Name: |
| Practice name and address: Telephone number:  Post code: Email address: |
| **Medical History:**  Pre-existing medical conditions: |
| Current medication: |

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| **Referrer details (if different from above):** |
| Name: Organisation:    Designation: |
| Address: Telephone Number:  Email: |

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| **Referral Details:** |
| Date of referral: |
| Please describe the traumatic events that the client has experienced: |
| Please describe the main presenting mental health difficulties and if possible, can you say how you think these relate to the traumatic experience/s? |
| Please describe the severity of the difficulties and how they are impacting on the client’s functioning. |
| What are the reasons for seeking a referral at this time? Has anything recently happened or changed? |
| Current living situation: |
| Previous contact with mental health services: Yes/No  If yes, please specify: |
| What other agencies/services are currently involved?  Contact? |

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| **Risk/Additional Vulnerabilities:** |
| History of suicide/self harm? Yes/No/Not Known  If yes, please describe the nature of self harm. Please include any recent episodes of self harm.  Is there any current risk of suicide/self harm? Yes/No  What is the current risk management plan? |
| Risk/History of violence to others? Yes/No/Not Known  If yes, please give details:  What is the current risk management plan? |
| Forensic History: Yes/No/Not Known  If yes, please provide details of recent convictions/cautions if known: |
| Child/adult protection issues and steps taken to address these (e.g. are any adults or children at risk of violence or abuse?) |
| Current substance misuse issues? Yes/No/Not Known  Current management plan **(Please include details of Care Manager and ensure that this referral has been discussed with Care Manager):** |

**Thank you- If you have any queries do not hesitate to contact us on 0141 303 8968**

**Please email completed form to:** [**GlasgowPsychological.TraumaService@ggc.scot.nhs.uk**](mailto:GlasgowPsychological.TraumaService@ggc.scot.nhs.uk)