Sunderland Primary Care and Psychological Wellbeing Service Self-Referral Information Form

Your Name:……
Male or Female:…….. Your date of birth:……..
Address:……
Main Telephone number: ……
Can a message be left on this number? YES / NO
Mobile number for appointment text reminders:……

Do you need an interpreter? YES / NO If yes, which language?.....

Please tick the box which best describes your ethnic background

White British		**Black British**	
White Irish		Black Caribbean	
Other White Background		Black African	
Asian British		Any other black background	
Indian		**Mixed**	
Pakistani		White & Black Caribbean	
Bangladeshi		White and Black African	
Any other Asian background		White and Asian	
Chinese		Any other mixed background	
Other ethnic groups		Prefer not to say	

If you are religious how would you describe your faith? (E.g. Christian, Muslim, Jewish etc)
……

Please indicate which of the following best describes your current work situation

Employed full-time (30 hrs or more per week)		Full-time student	
Employed part-time		Retired	
Unemployed		Full-time homemaker or carer	

Any drug/alcohol concerns? YES / NO (*if YES please give details)*

Do you live in a household with children? YES /NO (*if YES please give details)*

Any risk to SELF (e.g. suicide, self-harm, neglect)?
Current YES / NO (if YES please give details)
History YES /NO (if YES please give details)

Any known risk from OTHERS (e.g. domestic violence, bullying)?
Current YES / NO (if YES please give details)
History YES /NO (if YES please give details)

Any risk to OTHERS (e.g. violence, aggression, risk to children)?
Current YES / NO (if YES please give details)
History YES /NO (if YES please give details)

Are you currently receiving sick pay (statutory or other)? YES / NO

Are you currently receiving incapacity benefit, income support or unemployment benefits? YES / NO

Please answer the following questions below
Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10	Feeling nervous, anxious or on edge	0	1	2	3
11	Not being able to stop or control worrying	0	1	2	3
12	Worrying too much about different things	0	1	2	3
13	Trouble relaxing	0	1	2	3
14	Being so restless that it is hard to sit still	0	1	2	3
15	Becoming easily annoyed or irritable	0	1	2	3
16	Feeling afraid as if something awful might happen	0	1	2	3

Are you currently receiving sick pay (statutory or other)? YES / NO

Are you currently receiving incapacity benefit, income support or unemployment benefits? YES / NO

Of the Treatments listed, which would you like to take part in? ……

Once you have decided on a treatment choice, please complete the self-referral form provided by your GP and hand it back to the reception desk. If you have any problems completing the form, cannot see the treatment that would be the most helpful, or would prefer to have a clinician help you make this decision, please contact us on the Self Referral line.

Self Referral telephone 0191 566 5454

Self Referral Fax 0191 569 9151