NHS
Herts Valleys
Clinical Commissioning Group

GP Referral Form for Improving Access to Psychological Therapies (IAPT) Compliant Counselling

You can email this referral from any @nhs.net address to starlight.counselling@nhs.net

Demographic Information

First Name:			
Surname:			
Date of Birth: >16 years of age		**Gender:**	
Ethnicity		**NHS number:**	
Language		**Interpreter Required**	**Yes** ☐ No ☐

Address:	
Postcode:	

Landline number:	
Can voicemail messages be left on their landline?	Yes ☐ No ☐

Mobile number:	
Can voicemail messages be left on their mobile:	Yes ☐ No ☐

Referring GP's name:	
Name and address of your surgery:	
Practice e-mail address	

Current Employment/Education status	
Is currently working/school/college? ☐	Is not currently working/school/college? ☐

Assessing Risk

Is the patient currently a risk to themself?	***(MANDATORY PLEASE)***	Yes ☐ No ☐
Is the patient currently a risk to others?	***(MANDATORY PLEASE)***	Yes ☐ No ☐
Is the patient currently at risk from others?	***(MANDATORY PLEASE)***	Yes ☐ No ☐
If yes, this referral should not be made to AQP. Please complete a referral to HPFT		

Are their family and friends concerned about any of their behaviours?		Yes ☐ No ☐
If yes, please give details:		

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Current Difficulties

Current Difficulties Please describe the problem the person would like help with:

How long has this been a problem (approximate)		
A few weeks ☐	A few months ☐	A few years ☐

Are you aware if they have had contact with secondary care mental health services in the past?	Yes ☐ No ☐
If Yes, brief details (eg when and for what reason)	

Has the person received, or is currently receiving medication or other treatment for this problem?	Yes ☐ No ☐
If yes, please give details (e.g. what, when and for how long):	
Does the patient have any significant long term condition	Yes ☐ No ☐
Does the patient have any medical condition that may be contributing to the current problem?	Yes ☐ No ☐

Are there any issues with alcohol or recreational drugs?	***(MANDATORY FOR COMPLETION PLEASE)***
Alcohol (please circle):	Yes ☐ No ☐
Drugs (please circle):	Yes ☐ No ☐
If yes, please specify:	

Attached Patient Summary:
☐ Up-to date medications and allergies

Referring GP's Name/Signature		**Date:**	
Practice Details			

Thank you for completing this referral form. A member of our team will contact the patient in order to arrange a further appointment to discuss their needs. The service is required to see the patient within six weeks of the referral being made.

This form can be sent by e-mail : starlight.counselling@nhs.net

Please note that this form is secure if it is sent FROM an @nhs.net email address TO an @nhs.net email address.

Please note: This service is not able to provide immediate support in an emergency. If you require immediate urgent help, please contact the Single Point of Access (SPA) service on: 0300 777 0707