# Anxiety UK Well-being Assessment & Therapy Referral Form

**Name:**

**Address:**

**Post code:** **DOB (DD/MM/YYYY) :**

**Email address:**

(Please note: choosing to be contacted by email rather than via post or telephone will enable us to communicate with you effectively, whilst enabling us to keep costs down.)

**Daytime Telephone Number:** **Evening Telephone Number:**

(Please note it is essential that we are able to contact you by phone.)

**Is it acceptable to you for us to leave a message: (a) with someone answering your phone ☐**
**(b) on your answering machine ☐**

**Do you have any preference in relation to the gender of your therapist? (Please note this may limit availability for face to face referrals)**

Male ☐ Female ☐ No preference ☐

**How would you prefer your allocated therapist to make initial contact?**

Home phone ☐ Mobile phone ☐ Text message ☐ Email ☐

**CIOB Assist**

**GP's name:**

**GP's address:**

**GP's Tel No:**

**GPs email address:**

Providing an email contact for your GP is not essential, but may speed up the process should we need to contact them prior to you starting therapy

Important: neither your therapist nor Anxiety UK will usually need to contact your GP. However, as your welfare is of paramount importance, if issues of safety arise - for example, if either Anxiety UK or your therapist believes that you are a risk to yourself or to others - he/she may need to contact your GP before commencing treatment, or as appropriate during treatment. Unless the circumstances are exceptional, your therapist will always discuss this with you before making contact with your GP. Therefore, it is essential we have your GP contact details as, without these, we cannot process your application.

*** Please note, if you are under the age of 16 years of age we will require a letter from your GP giving their permission for us to provide access to treatment as well as confirmation from your parent/guardian of their consent for you to access this service. ***

**I give my consent to Anxiety UK to contact my GP in the event of any of the circumstances above being met**

**Signature …….**

**Emergency Contact Name:**

**Emergency Contact Phone number:**

**Please give brief details of why you wish to see an Anxiety UK therapist and which conditions you are currently experiencing or receiving intervention for.**

**If you are presenting with PTSD have your symptoms been present for more than one month?**

Yes ☐ No ☐ Not applicable ☐

**Are you currently in receipt of any other form of therapy?**

Yes ☐ (please give details) No ☐

**Are you currently seeing any other mental health professional at present**

**(e.g. psychologist/psychiatrist/counsellor)?**

Yes ☐ (please give details) No ☐

**Have you accessed any mental health support services <u>within the last 3 years</u> e.g. crisis services/home treatment team, psychiatrist, community mental health team, social worker, psychologist, IAPT service, counsellor, therapist etc.?**

Yes ☐ (please give details below) No ☐

**<u>Name, address & contact tel. number of service/practitioner</u>**

**Date accessed:**

**Are you currently taking any prescribed psychiatric medication (e.g. antidepressants)?**

Yes ☐ No ☐

Please state medication prescribed:

**Do you have any substance misuse difficulties (including alcohol, drugs – this includes misuse of non-prescribed/prescribed medication etc.) that would be problematic or may interfere with your ability to attend and fully engage with your therapy sessions?**

Always ☐ Sometimes ☐ Never ☐

**Have you had thoughts of suicide within the past month?**

Yes ☐ No ☐

If you have answered 'yes' please select from the dropdown on a scale of 1-10 how intense these thoughts have been (1 = fleeting thoughts of not wanting to be here, 10 = I have a plan and will to carry out my thoughts).

**At Anxiety UK we support people with a wide range of needs, if you have any additional adjustments required to improve the quality of your experience in accessing therapy support please advise us in this section**

**Do you have any visual or hearing impairment that will impact your therapy support?**

Yes ☐ (please give details) No ☐

**Do you have someone (like a family member, friend or professional) help you read letters and information leaflets?**

Yes ☐ (please give details) Sometimes ☐ No ☐

**How often do you have problems filling out questionnaires by yourself?**

Always ☐ Sometimes ☐ Never ☐

**Do problems with numbers make it difficult for you to manage day-to-day activities such as paying bills and reading timetables?**

Always ☐ Sometimes ☐ Never ☐

**Please give details of any other needs you have that may affect your access to therapy support:**

**IMPORTANT: PLEASE READ THE FOLLOWING TERMS & CONDITIONS:**

**Your Privacy**

Anxiety UK is aware that email is not 100% secure.

**If you have requested that Anxiety UK correspond with you by e-mail this will require e-mailing your personal data outside of our own IT network. We need to inform you there is the risk of data loss by e- mailing outside our IT network. Before we can proceed with your request please provide written confirmation (this can be an e-mail response) that you accept the risk of data loss**

**Please confirm below your preferred method of dealing with your personal data**

☐ **I GIVE MY CONSENT** FOR ANXIETY UK TO CORRESPOND WITH ME IN RELATION TO MY THERAPY REFERRAL BY EMAIL AS THIS IS MY PREFERRED METHOD OF COMMUNICATION. I ACKNOWLEDGE THAT THIS MAY REQUIRE EMAILING PERSONAL DATA OUTSIDE OF YOUR IT NETWORK and I accept that there is a risk of data loss by emailing outside of the network. I understand that Anxiety UK will store this information safely in files and IT systems, and that I can withdraw my consent for them to hold my information at any time by writing to them.

☐ **I DO NOT GIVE MY CONSENT** FOR ANXIETY UK TO CORRESPOND WITH ME IN RELATION TO MY THERAPY REQUEST BY EMAIL

If you have any concerns about confidentiality and the data contained within this document being passed to us via email then we are happy to accept encrypted emails and documents. You can then call to provide the password over the phone. If you would like details on how to encrypt this document please contact services@anxietyuk.org.uk and the details will be passed over to you.

**Please be aware that when signing up to this wellbeing assessment and potential further therapy you should be fully committed. If for some reason you cannot make an appointment please do take action to rearrange a scheduled appointment. If you cancel your appointment with less than 48 hours' notice the full fee of the session is still payable. These sessions are funded by CIOB Assist to provide support to those who are in need so please make efforts where necessary to avoid wasted costs.**

☐ **I/The client consent to CIOB Assist sharing my personal information with Anxiety UK and for Anxiety UK to share information concerning my well-being assessment and therapy referral with CIOB Assist.**

☐ **I further consent to Anxiety UK to contact my GP, emergency services or other relevant professional and responsible adults if required to do so.**

☐ **I have read and understand all aspects of my therapy application with Anxiety UK.**

**Signature:** _____ **Date:** _____

Once you have completed this form in full, please send to **referrals@anxietyuk.org.uk**