SPoR official use only

IAPT ID #

NHS N°

RIO N°

SPoR STAMP

DATE RECEIVED

Bedfordshire NHS
mental health and wellbeing service
provided by ELFT

TREND HOUSE, DALLOW ROAD
• LUTON • LU1 1LY
ELT-TR.BEDFORDSHIREWELLBEINGSERVICE@NHS.NET
TELEPHONE: 01582 393 144 • FAX: 01582 393 141

Referral Form — Single Point of Referral (SPoR)

PLEASE NOTE:** to avoid any delays to us arranging an appointment for you, please complete all sections making sure we have your patient's up to date contact numbers. **If you have any questions or need any help in filling in this form, please call us on the above number.

Eligibility Criteria

In order to be eligible for this service you must be either a resident of Bedfordshire county or have a GP in Bedfordshire, and aged 18 and above. We are sorry that we cannot accept individuals aged 16 to 17 who are in full time education.

Patient's Details

*NHS Number:

*Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ other ☐ Please specify: _____
(Please mark with X)

*Date of Birth: Day Month Year

*First Name:

*Last Name(s):

*Address:

*Post Code:

*Gender: Male ☐ Female ☐ Other ☐ Please specify: _____
(Please mark with X)

*Contact Numbers:

*Permission to leave messages on phone?

	Voice message	*text messages*
Home:		
Mobile:		
Other:		

(Please indicate yes/no above)

Please specify: _____

*Permission to send written communication? Yes ☐ No ☐

*Permission to contact by phone? Yes ☐ No ☐
(Please mark with X)

E mail:

GP Details

*Address:

*Post Code:

*GP Name:

* Contact Number:

Personal Information

Nationality: ☐ English ☐ Scottish ☐ Irish ☐ Welsh ☐ British ☐ Other (Please specify) _____

Ethnicity:

☐ White British	☐ Asian /Asian British	☐ Black /Black British	☐ Mixed	☐ Chinese
☐ White Irish	☐ Indian	☐ Caribbean	☐ White & Asian	☐ Vietnamese
☐ Eastern European	☐ Pakistani	☐ African	☐ White & Black Caribbean	☐ Japanese
☐ White other	☐ Bangladeshi	☐ Nigerian	☐ Mixed other	☐ Filipino

☐ Any Other Ethnic Origin (Please specify) _____
☐ I do not wish to specify an ethnic origin

Preferred Language: ☐ English ☐ Bengali /Sylheti ☐ Urdu ☐ Punjabi ☐ Tamil ☐ Arabic ☐ Polish
☐ Other (Please specify) _____

Please tell us:

1) Please indicate the presenting problems and any relevant history:

2a) Have they received help from any other services for mental health difficulties (eg. CMHT, Inpatient unit, University)?

YES ☐ (If yes, please move to 2b and give details)
NO ☐ (Please move to Q3)

2b) Please tick which services they received help from

CMHT (Community Mental Health Team) ☐
Inpatient Unit ☐
Crisis Team ☐
Other ☐ (please specify) _____

3) Have they had any issues / difficulties with the police or social services?

YES ☐ (If yes, please give details) _____

NO ☐

4) Are they currently taking any antidepressants or anti-anxiety medication?

YES ☐ (If yes, please give the name and dosage prescribed) _____

NO ☐

5) Any Drug/ Alcohol concerns?

YES ☐ (If yes, please give details) _____

NO ☐

6) Please tell us about their special requirements including any language needs.

Referrers Details (Non GP ONLY)

*Referral Source: CMHT ☐ ☐ Other ☐ Please specify: _____
Please mark with X

*Address:

*Post Code:

*Full Name:

Referrer Stamp

Please Send Completed Referral To: Fax: 01582 393 141or Email: Elt-tr.BedfordshireWellbeingService@nhs.net