

RETURN VIA E-MAIL (cancer.psychologicalsupport@stgeorges.nhs.uk)

OR VIA POST/FAX USING THE DETAILS AT THE BOTTOM OF THE FORM

Macmillan Cancer Psychological Support (CaPS) Team Referral Form

 (Counselling, Clinical Psychology & Liaison Psychiatry)

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| **PATIENT DETAILS** |
| Date of Referral:       | Patient [ ]  / Carer [ ]  (for carers, provide linked Patient Name/Hospital No. here but carer’s own details in the remainder of the form:      ) |
| Surname:      | Forename:       | Gender:       |
| Hospital No:       | DOB:        | Marital Status:      |
| Outpatient [ ]  / Inpatient [ ]   | Ward (if applicable):      | Planned Discharge date:      |
| Consultant(s):      | Team/MDT:      |
| Primary Diagnosis:      | Current Treatment Status/Plan:      |
| Home Address:      | GP Name/Address/Telephone:           |
| Contact Details (Mobile & Landline):       |

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| **REFERRER DETAILS** |
| Name:      Professional Role:       | Contact details (including telephone no.):      |

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| **INCLUSION CRITERIA** |
| **Please ensure that the patient you are referring:** |
| Is being referred for psychological issues related to cancer or impacting upon cancer treatment | [ ]  |
| Has consented to be seen by our service (please call/bleep if consent cannot be established) | [ ]  |
| Is 18 years old or over | [ ]  |
| Is or has been under the care of (or a carer for someone at) St George’s being treated for cancer  | [ ]  |
| Is able to communicate (e.g. through speech, writing, drawing) | [ ]  |

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| **PRIORITY LEVEL** | **URGENT ADVICE/ASSESSMENT** |
| Please make an assessment of need before making a referral – distress is not in of itself an appropriate reason for specialist psychological support. Do consider the duration and severity of difficulties and contact us if unsure. Routine patient referrals may be placed on waiting list. [ ]  **Routine** [ ]  **Priority e.g.** **issue compromising medical care****days/weeks from end of life** **suspected risk of suicide/self-harm** | If you require **urgent** advice/assessment, please BLEEP 7737 initially (and follow this with a completed form after speaking to one of our team). Using this form alone will not get you an urgent response. Reasons may include: * Risk of suicide/self-harm/harm to others
* Treatment refusal (conduct a capacity assessment first)
* Active psychotic symptoms e.g. hallucinations/delusions (discuss with medical team prior to bleeping)
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| **REASONS FOR REFERRAL** |
| **Summarise the reason for referral here:**      |
| **Please tick as many as you feel apply:** |
| [ ] Suicidal ideation/risk [ ] Active psychosis e.g. hallucinations/delusions[ ]  Treatment refusal[ ] Psychological pre-surgical assessment e.g. BRACA/RRM[ ] Generalised anxiety / worry[ ] Specific Anxiety e.g. panic attacks/phobias [ ] PTSD/Trauma (including ITU-related issues)[ ] Score of >7 on Holistic Needs Assessment (HNA)[ ] Depression / low mood[ ] Issues preventing treatment / rehabilitation[ ] Coping and adjustment issues[ ] Coping with end of life care Issues[ ] Decision-making difficulties[ ] Mental capacity issues | [ ] Relationship issues[ ] Carer burden[ ] Support with issues relating to children < 18[ ] Fear of recurrence (in survivorship)[ ] OtherSurvivorship issues[ ] Pain (requiring specific psychological help)[ ] Sleep difficulties[ ] Side-effect management e.g. fatigue/nausea[ ] Adjustment to cognitive impairment[ ] Psycho-sexual difficulties[ ] Body image problems[ ] Communication issues/breakdown with HCPs[ ] Interaction with pre-existing mental health problem[ ] Other       |

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| **ADDITIONAL QUESTIONS** |
| **To the best of your knowledge:** |
| Has the patient been referred to our service previously? |       |
| Does the patient have a pre-existing mental health diagnosis (including alcohol/ substance misuse)? If yes, do they have a mental health team? (provide detail) |       |
| Does the patient specifically need to be seen by a psychiatrist? |       |
| Has the patient expressed a preference regarding the gender of their clinician? |       |
| Does the patient require an interpreter or have any other barriers to communication (if yes, please provide detail)? |       |
| Have an existing counsellor/psychologist/psychiatrist elsewhere? |       |

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| **OTHER SERVICES/INDIVIDUALS INVOLVED** |
| Please provide information about any key individuals involved e.g. family members, health professionals, social services, mental health teams:      |

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| **ANY OTHER HELPFUL INFORMATION** |
| If there is any other information that you think might be helpful to us (e.g. duration of difficulties, key treatment-related or psychiatric medication) please enter it here:      |

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| **CONTACTING THE TEAM** |
| **Referrals forms should ideally be returned electronically via email (*cancer.psychologicalsupport@stgeorges.nhs.uk*)** but can also be posted/faxed using the below details. Should you wish to contact the Macmillan Cancer Psychological Support (CaPS) Team for help completing this referral form, advice about working with a patient or for any other reason, please do not hesitate to get in touch. |
| EMAIL: POST: PHONE: FAX: BLEEP (urgent only): | ***cancer.psychologicalsupport@stgeorges.nhs.uk***Macmillan Cancer Psychological Support (CaPS) Team, Phoenix Centre, St George’s Hospital, Blackshaw Road, London SW17 0QT 020 8725 0461020 8266 65157737 |