

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  (if carer, 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: | | Known to Palliative care  Y  N |
| 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/bleep no.): |

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| **REFERRAL CRITERIA** | |
| **Please ensure that the patient you are referring:** | |
| Is 18+ and being referred for psychological issues related to cancer or impacting upon cancer treatment |  |
| Has consented to be seen by our service (please call if capacity to consent cannot be established) |  |
| Is or has been under the care of (or a carer for someone at) St George’s being treated for cancer |  |

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| **REFERRAL TYPE** |
| Please tick as many as apply: |
| **Psychology/Counselling** (e.g. psychological/supportive therapeutic intervention)  **Psychiatry** (e.g. psychiatric medication review, complex mental health comorbidities) |

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| **REFERRAL PRIORITY** |
| Please assess level of need before making a referral. Consider the duration and severity of difficulties and contact us if unsure about a referral. Distress is not in of itself a sufficient reason for specialist psychological support. Please be aware routine outpatient referrals may wait a few weeks for an appointment.  *If you require* ***urgent*** *psychiatric advice/assessment, please bleep Liaison Psychiatry (BLEEP 6501).*  **Routine**  **Priority e.g.** **issue compromising medical care**  **days/weeks from end of life**  **suicidal ideation (without immediate risk)** |

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| **REFERRAL BACKGROUND** | |
| **To the best of your knowledge:** | |
| Has the patient been referred to our service previously? |  |
| Does the patient have an existing mental health diagnosis (inc. alcohol/ substance misuse)? If yes, do they have a mental health team? (provide detail) |  |
| Does the patient have an existing counsellor/psychologist/psychiatrist elsewhere? (provide detail) |  |
| Is an interpreter or any adaptation to communication required (provide detail) |  |

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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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| **REASONS FOR REFERRAL** | |
| **Summarise the reason for referral here:**  [Include any pertinent treatment-related information such as duration of difficulties, support/interventions offered to date and any psychiatric medication] | |
| **Please tick as many as you feel apply:** | |
| Suicidal ideation/risk (provide assessment of risk above)  Psychiatric medication review e.g. antidepressants  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 cancer progression/recurrence  Othersurvivorship-related issues  Pain management  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 issue  Other |

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| **SPECIFIC PATIENT NEEDS/PREFERENCES** |
| Please provide information about:   * barriers to access e.g. physical/mobility * additional patient preferences e.g. gender of CaPS clinician, availability for appointments |

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| **CONTACTING THE TEAM** | |
| **Completed referral forms should ideally be returned via email (**[***cancer.psychologicalsupport@stgeorges.nhs.uk***](mailto:cancer.psychologicalsupport@stgeorges.nhs.uk) **if within the Trust,**[***stgh-tr.cancer.psychologicalsupport@nhs.net***](mailto:stgh-tr.cancer.psychologicalsupport@nhs.net)**if outside the Trust)** 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 get in touch. | |
| EMAIL:  POST:  PHONE:  FAX: | ***cancer.psychologicalsupport@stgeorges.nhs.uk***  Macmillan Cancer Psychological Support (CaPS) Team, Phoenix Centre, St George’s Hospital, Blackshaw Road, London SW17 0QT  020 8725 0461  020 8266 6515 |