

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*** **if within the Trust,*****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 0461020 8266 6515 |