**Referral of patient with specific anxiety disorder for outpatient psychological therapy to Centre for Anxiety Disorders & Trauma (CADAT), Maudsley Hospital, 99 Denmark Hill, London, SE5 8AZ, 0203 228 2101**

*Please click on “Enable Editing” and then save as a Word document to complete online and return via email to* *cadatreferrals@slam.nhs.uk*

**Referral details**

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| Name of Patient: |  | Patient NHS number (if known) |  |
| Patient DOB:(dd/mm/yyyy) |  | Patient contact phone number |  |
| Patient Address: |  | This patient lives in\* | Southwark/Lambeth/Lewisham/Other |

\* NB: For patients who are living in, or have registered GPs in, the boroughs of Lambeth, Lewisham or Southwark, please do not complete this form, unless you are referring under the Highly Specialised Service (HSS; see referral criteria below). Please instead refer your patient to their local IAPT (primary care) or Community Mental Health Team (secondary care). For national referrals from these boroughs please refer direct to the appropriate borough-based Specialist Service Funding Panel to secure funding in advance.

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| Referral Date: |  | Name of referrer: |  |
| Referrer’s Organisation: |  | The referrer is the patient’s: | GP / Psychiatrist / CMHT member / Other (specify)  |
| Referrer’s address\* |  |
| Referrer’s email address |  |
| Patient’s GP:  |  |
| GP Address\* (if different from referrer): |  |
| GP Phone Number: |  |

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| Does the patient have a community mental health team? | Yes / No |
| CMHT name & address (if applicable and different from referrer): |  |
| Name of Care Co-Ordinator (if applicable): |  |

Please note that all treatment options are outpatient services, and our clinic predominantly offers specialist Cognitive Behaviour Therapy for specific anxiety disorders, usually on a once weekly basis. We are a specialist service that treats both local and national patients, and we have waiting times for both assessment and treatment.

We offer treatment for the following specific anxiety disorders only. Please select which of the following disorders below is the patient’s **main presenting problem/s** that they are seeking help for, or contact us on 02032282101 to discuss first if you are not sure.

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| **☐** | **Obsessive Compulsive Disorder** | **☐** | **PTSD** without comorbid dissociation |
| **☐** | **Body Dysmorphic Disorder** | **☐** | **Panic Disorder** |
|[ ]  **Health Anxiety** | **☐** | **Social Anxiety Disorder** |
| **☐** | **Generalized Anxiety Disorder**(excessive and uncontrollable worry) | **☐** | **Specific Phobia****(please specify type)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **☐** | **Misophonia**  |  |  |
| **☐** | **Depersonalisation Disorder** |  |  |

Please give a short description of the main problem/s the person needs help with, and any other relevant information, e.g. other diagnoses or previous treatments.

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Please put an “X” in ONLY ONE of the boxes for the service stream you would like to refer this patient under (i.e. “Patient Choice” OR “National Specialist Service” OR “Treatment Resistant Obsessive Compulsive Disorder/Body Dysmorphic Disorder”). We may be unable to accept the form if you do not do this.

Please also indicate whether the relevant criteria are met. If you are not sure which service stream to select, please call us to discuss first, on 02032282101.

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|  **Patient Choice only, please confirm** | ***Delete as applicable*** |
| Is this referral being made by a GP? | Y/N |
| Have you, as the GP, discussed options with the patient including our clinic and has the patient chosen to be seen by us? | Y/N |
| Is the patient currently receiving or on a waiting list for any other treatment for this problem through any other NHS service? | Y/N |
| Is the patient is actively suicidal? | Y/N |
| Does the patient does need support from their local community mental health services? *Please note we are not an emergency service, and for patients with significant mental health difficulties we usually suggest you refer to their CMHT, who may choose to refer on to our clinic.* | Y/N |
| If approved for Patient Choice treatment, the patient will typically be offered 12 sessions of specialist CBT (with an absolute maximum of 20).**Please note:** if we assess this patient under this Patient Choice service stream but they are found not to meet criteria for treatment under Patient Choice as above, then our clinic will have to apply for funding from the patient’s local CCG, and that treatment will be subject to funding approval. |  |
|  **National Specialist. Please confirm:** | ***Delete as applicable*** |
| Is this referral being made by a Community Mental Health Team or equivalent? | Y/N |
| Is this referral being made by a GP, but this patient does not present with risk or complex needs which would require the input of a CMHT or similar? *(please note comment above on how our clinic is not an emergency service).* | Y/N |
| Do you agree that upon acceptance of this referral, our clinic will have to apply for funding from the patient’s local CCG for an assessment? | Y/N |
| Do you agree that if we assess the patient as suitable for this service stream, our clinic will have to apply for funding from the patient’s local CCG, and the treatment offer will be subject to funding approval? | Y/N |

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|  **Treatment Resistant Obsessive Compulsive Disorder / Body Dysmorphic Disorder Service (‘Highly Specialised Service’, HSS). Please confirm:** | ***Delete as applicable*** |
| Does the patient have severe OCD or BDD? | Y/N |
| Has the patient taken at least two SSRIs in the past, at maximal tolerated dose? | Y/N |
| Has the patient completed *at least* two courses of CBT for their OCD/BDD? | Y/N |
| Do you agree that upon acceptance of this referral, we will offer the patient an assessment and that if we assess the patient as suitable for this service stream, treatment will be subject to approval from the HSS funding panel. Funding for this service stream comes from NHS England (i.e. it is not funded by local CCGs).  | Y/N |
| Please specify medications, dosages and dates taken (HSS referrals only). |
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