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| **Referral Form**  **Op RESTORE are only able to accept referrals for service-related physical health conditions**  This form should be completed by the veteran’s GP practice in block capitals or electronically to ensure all information is legible.  Please ensure all sections are fully completed and details of any existing referrals are included on page 2.  Referrals will only be logged upon receipt of a completed referral form from the GP practice and supporting clinical letters – this provides assurance that the veteran’s GP practice gives Op RESTORE permission to review the clinical information and make onward referrals as appropriate. |

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| **Veteran Name:** | | **Date of Birth:** | | | |
| **Veteran Home Address:** | | **Ethnicity:**  Asian or Asian Black  Black, Black British, Caribbean or African  Mixed or multiple ethnic groups White  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Prefer not to say | |          | |
| **NHS Number:** | | **Gender Identity:**  Male  Female  Other \_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Contact email address:** | | **Contact phone number:** | | | |
| **Preferred contact method during working hours**  **Email**  **Phone/Text**  | | **Language / communication difficulties?** Please specify | | | |
| **GP Practice & Postcode:**  Email Address: | | | | | |
| **Military Service Number:** | | **Year of Discharge from Armed Forces:** | | | |
| **Army** | **RAF** | **Royal Navy** | **Royal Marines** | | |
| **Service-related Physical Health condition/injury veteran is being referred for:** | | |  | | |
| **Has the standard NHS pathway been initiated for this condition/Injury?**  **If no, please specify why** | | |  | | |

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| **Details of service-related physical health need and reason for referral.** | |
| **Details of any current referrals in place to any clinician for the service-related physical health condition/injury. Please include details of to whom, which Trust and the date the referral was made:** | |
| **Details of any mental health need and professionals involved in the veteran’s care:**  *Veterans with mental health needs can be referred to* [*NHS Op COURAGE*](https://www.nhs.uk/nhs-services/armed-forces-community/mental-health/veterans-reservists/)*.* | |
| **If veteran has been in crisis in the last 12 months, please confirm the agency currently supporting them: -** | |
| **Please list any other professionals or charities (military or other) currently involved in the veteran’s care that you are aware of:**  Name: Service: Contact number: | |
| **Are there any concerns known to the referring clinician regarding OpR contacting the veteran to discuss their healthcare and wellbeing?** | **Yes / No** |
| The veteran being referred confirms that their care and medical details can be discussed with the following if necessary (eg spouse, family member, advocate): -  Name Relationship Contact Information | |
| This referral form has been discussed in full with the patient.  The veteran is aware this referral form will be shared with those supporting their care through Op RESTORE (including but not limited to Pain Management services, Mental Health providers and military charities), has consented to this and there is a contact number on the referral form.  **As part of this referral, the patient will be contacted by Op RESTORE and/or a Support Worker from a military charity to support them through the service.**  As a clinician you are agreeing for Op RESTORE to refer your patient to the most appropriate clinician to treat their condition where applicable. You will be notified of the outcome of this referral to OpRESTORE.  **I confirm all the above** | |
| **Name of Referring Clinician:** **Date:** | |
| **Once the form is completed, please send along with a copy of the veteran’s summary care record and any consultant letters, therapy reports, procedure outcomes from the last 3-4 years to** [Imperial.oprestore@nhs.net](mailto:Imperial.oprestore@nhs.net)  **Please note: any incomplete or illegible forms will not be processed.** | |