



Talking Change Self-Referral Forms

Your contact details

Title & name _____

Date Of Birth _____

Address _____

_____ Postcode _____

Mobile phone _____ May we leave a message? Yes No

Home phone _____ May we leave a message? Yes No

Email address _____

GP surgery _____

Name of GP you last saw _____

Talking Change

1st Floor, 8F The Pompey Centre
Fratton Way, Portsmouth
PO4 8TA
Tel: 023 9289 2920
Fax: 023 9289 2947
www.talkingchange.org.uk

Reasons for this self-referral. Please describe your current difficulties. Please give details of your symptoms, when they began and how you are coping at the present time. Please tell us whether you are using any medication, alcohol or substances and if you are currently in contact with any other services for this problem. (Please continue overleaf if needed)

Do you have any holidays or planned trips away from home in the next four weeks as we may try to contact you to discuss your self-referral? (Please give dates if so).

If you need any help with this form contact us on 023 9289 2920 SRPack V5 04/11



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Reasons for this self-referral continuation sheet

Please list any previous contact with other mental health professionals.

Do you have any special requirements to enable you to use this service?
(e.g. an interpreter, disabled access).

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GAD7

Over the last week, how often have you been bothered by any of the following problems?
(Please tick one box for each question.)

	Not at all	Several days	More than half the days	Nearly every day
1) Feeling nervous, anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Being so restless that it is hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Phobia scale

Choose a number from the scale below to show how much you would avoid each of the situations or objects listed. Write the **number in the box** opposite the situation.

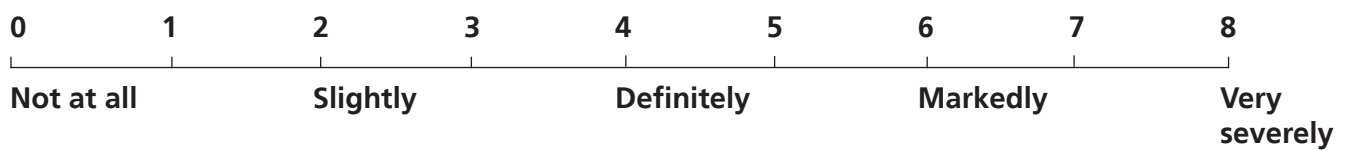
0	1	2	3	4	5	6	7	8	
Not at all	Slightly avoid it		Definitely avoid it		Markedly avoid it		Always avoid it		
1) I avoid social situations due to a fear of being embarrassed or making a fool of myself								<input type="checkbox"/>	Number
2) I avoid certain situations because of a fear of having a panic attack or other distressing symptoms (such as loss of bladder control, vomiting or dizziness)								<input type="checkbox"/>	Number
3) I avoid certain situations because of a fear of particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying)								<input type="checkbox"/>	Number

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Work and social adjustment

People's problems sometimes affect their ability to do certain day to day tasks in their lives. To rate your problems, look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity.

Please insert the **number in the box** next to the day to day task.



1) **Work** - if you are retired or choose not to have a job for reasons unrelated to your problem, please tick N/A (not applicable).

N/A

Your ability to work is affected by your problems, please insert appropriate number in box

Number

2) **Home management** - cleaning, tidying, shopping, cooking, looking after home/ children, paying bills etc

Number

3) **Social/leisure activities** - with other people, e.g parties, pubs, outings, entertaining etc

Number

4) **Private leisure activities** - done alone, e.g reading, gardening, sewing, hobbies, walking etc

Number

5) **Family and relationships** - form and maintain close relationships with others including people that I live with

Number

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PHQ9

Over the last week, how often have you been bothered by any of the following problems?
(Please tick one box for each question.)

	Not at all	Several days	More than half the days	Nearly every day
1) Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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CORE-OM

Please read each of the 34 statements and think how often you felt this way over the last week. Then tick the box that is closest to this.

Over the last week

	Not at all	Only occasionally	Sometimes	Often	Most or all of the time	
1) I have felt terribly alone and isolated	<input type="checkbox"/> ⁰	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> F
2) I have felt tense or nervous	<input type="checkbox"/> ⁰	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> P
3) I have felt I have someone to turn to for support when needed	<input type="checkbox"/> ⁴	<input type="checkbox"/> ³	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁰	<input type="checkbox"/> F
4) I have felt ok about myself	<input type="checkbox"/> ⁴	<input type="checkbox"/> ³	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁰	<input type="checkbox"/> W
5) I have felt totally lacking in energy and enthusiasm	<input type="checkbox"/> ⁰	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> P
6) I have been physically violent to others	<input type="checkbox"/> ⁰	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> R
7) I have felt able to cope when things go wrong	<input type="checkbox"/> ⁰	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁴	<input type="checkbox"/> F
8) I have felt troubled by aches, pains or other physical problems	<input type="checkbox"/> ⁰	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> P
9) I have thought of hurting myself	<input type="checkbox"/> ⁰	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> R
10) Talking to people has felt too much for me	<input type="checkbox"/> ⁰	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> F
11) Tension and anxiety have prevented me doing important things	<input type="checkbox"/> ⁰	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> P
12) I have been happy with the things I have done	<input type="checkbox"/> ⁴	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ⁰	<input type="checkbox"/> F
13) I have been disturbed by unwanted thoughts and feelings	<input type="checkbox"/> ⁰	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> P
14) I have felt like crying	<input type="checkbox"/> ⁰	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> W
15) I have felt panic or terror	<input type="checkbox"/> ⁰	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> P
16) I made plans to end my life	<input type="checkbox"/> ⁰	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> R
17) I have felt overwhelmed by my problems	<input type="checkbox"/> ⁰	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴	<input type="checkbox"/> W

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	Not at all 0	Only occasionally 1	Sometimes 2	Often 3	Most or all of the time 4	OFFICE USE ONLY
18) I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> P
19) I have felt warmth or affection for someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> F
20) My problems have been impossible to put to one side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> P
21) I have been able to do most things I needed to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> F
22) I have threatened or intimidated another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> R
23) I have felt despairing or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> P
24) I have thought it would be better if I were dead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> R
25) I have felt criticised by other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> F
26) I have thought I have no friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> F
27) I have felt unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> P
28) Unwanted images or memories have been distressing me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> P
29) I have been irritable when with other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> F
30) I have thought I am to blame for my problems and difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> P
31) I have felt optimistic about my future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> W
32) I have achieved the things I wanted to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> F
33) I have felt humiliated or shamed by other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> F
34) I have hurt myself physically or taken dangerous risks with my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> R

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A little bit about you

We collect information about all the people who refer themselves to our service in line with Department of Health requirements and the Solent NHS Trust policy for equality and access. Within Talking Change we use the information to improve our provision of services to all members of the Portsmouth population. Some of the information is submitted to the Department of Health for analysis at a national level.

If you **DO NOT** want your personal information to be submitted to the Department of Health for inclusion in national statistics please tick this box.

Your treatment **WILL NOT** be affected by this decision.

1) Gender and living arrangements

Please tick the appropriate boxes

i Male Female Transgender Rather not say

ii Living alone Living with others

2) Employment status Please tick one

- Employed full-time
- Employed part-time
- Unemployed on Job Seekers Allowance
- Long term disability claiming Incapacity Benefit, Income Support or both; or Employment and Support Allowance
- Homemaker, looking after your home and/or family and not employed'
- Unemployed and not receiving benefits
- Unpaid voluntary work - receiving benefits
- Retired from work, not on work related benefits
- Education with or without part-time work

3) Employment and training support

We have Employment Advisors who are part of our team. They may be able to help you look for work or training, or help with applications or interviews. They can also help you negotiate your return to work with your employer.

Would you be interested in speaking with one of our Employment Advisors? Yes No

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4) Where did you first hear about Talking Change?

5) British Armed Forces - are you

- Currently serving in the Armed Forces?
- Ex-Armed Forces personnel?
- A dependent of a serving member of the Armed Forces?
- A dependent of ex-serving member of Armed Forces?
- None of the above?
- Unsure

6) Are you or your partner currently pregnant or had a baby in the last 12 months?

- Yes No Rather not say

7) Disability

Under the Disability Discrimination Act 1995, a disabled person is described as anyone with "a physical or mental impairment which has a substantial and long term adverse effect on his or her ability to carry out normal day to day activities".

Do you consider yourself to have any of the following disabilities? **Yes** **No** **Rather not say**

Do you consider yourself to have any of the following disabilities?	Yes	No	Rather not say
- Behaviour and emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Manual dexterity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Memory of ability to concentrate, learn or understand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Mobility and Gross Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Perception of physical danger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Personal self-care and continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Progressive conditions e.g. <i>Multiple Sclerosis, Motor Neurone Disease, HIV</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Sight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Other (please describe) _____			

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8) Long term health conditions

Do you consider yourself to have a long term health condition?

Yes No Rather not say

9) Sexual orientation

We believe that it is helpful to gather this information for the purpose of determining equality of access. Although analysis will be more effective if everyone provides a response, we appreciate that this is a sensitive and personal question. **Please be aware that your response is voluntary.**

Heterosexual Not sure
 Homosexual Rather not say
 Bisexual

10) Ethnic origin - please tick the appropriate category

- | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|
| A <input type="checkbox"/> | British | K <input type="checkbox"/> | Bangladeshi |
| B <input type="checkbox"/> | Irish | L <input type="checkbox"/> | Any other Asian Background |
| C <input type="checkbox"/> | Any other White Background | M <input type="checkbox"/> | Caribbean |
| D <input type="checkbox"/> | White and Black Caribbean | N <input type="checkbox"/> | African |
| E <input type="checkbox"/> | White and Black African | P <input type="checkbox"/> | Any other Black Background |
| F <input type="checkbox"/> | White and Asian | R <input type="checkbox"/> | Chinese |
| G <input type="checkbox"/> | Any other Mixed Background | S <input type="checkbox"/> | Any other Ethnic Group |
| H <input type="checkbox"/> | Indian | | |
| J <input type="checkbox"/> | Pakistani | Z <input type="checkbox"/> | Rather not say |

11) Religion or belief

What is your religion/belief? _____

Please state if you have none or would rather not say _____

Date form completed _____ **The end - thank you**

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