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| **We are only able to accept referrals for service-related physical health conditions**  This form should be completed 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. |

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| --- | --- | --- | --- | --- | --- |
| **Reason for Referral:** | | | | | |
| **Veteran name:** | | | **Date of Birth:** | | |
| **Veteran address:** | | | **Gender:** | | |
| **NHS Number:** | | |
| **Contact email address:** | | | **Nationality:** | | |
| **Contact number:** | | | **Marital Status:** | | |
| **Preferred contact method during working hours**  **Email Phone** | | | **Is the patient registered disabled?** | | |
| **Language / communication difficulties?** Please specify | | |
| **GP Practice & GP Name:**  Email Address: | | | | | |
| **Service Number:**  **Reserves / Regular** | | | **Year of Discharge from Armed Forces:** | | |
| **Royal Navy** | **Royal Marines** | | **Army** | **RAF** | |
| **Physical Health condition/injury veteran is being referred for:** | | |  | | |
| **Was this condition/injury sustained in-service?** | | |  | | |
| **Details of service-related physical health need including any treatment in the last 3-5 years – please attach any consultant letters, therapy reports, procedure outcomes:** | | | | | |
| **Any current referrals in place to any clinician for the service-related physical health condition/injury, please details to who, 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* [*Referrals - Veterans NHS Wales*](https://www.veteranswales.co.uk/how-to-self-refer.html) | | | | | |
| **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: | | | | | |
| 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 Veterans Trauma Network Wales (VTN) Referral Form has been discussed in full with the patient.  I **confirm** the veteran being referred is content to share their details as appropriate with those supporting their care through VTN Wales.  **As part of this referral, the patient may be contacted by a Defence Medical Welfare Service Support Worker to support them through the VTN Wales process. The patient is aware of and has consented to this and there is a contact number on the referral form.**  **I confirm all the above** | | | | | |
| **Name of Referring GP:** **Date:** | | | | | |
| **Please send this form and any previous scans, imaging, referral details and relevant clinical letters relating to the physical injury to**  VeteransTraumaNetwork@wales.nhs.uk | | | | | |