

**Gateshead Talking Therapies**

**SELF-ASSESSMENT**

**SECTION 1: INFORMATION**

* Self-assessment is designed to help you access the service at the earliest opportunity.
* Your answers will help us understand your difficulties and identify the correct treatment.
* **It is important that you answer ALL the questions as fully as possible. If you don’t then this could delay your treatment.**
* Once we have received your assessment we will get in touch with you either by telephone or letter to inform you how our service can help you.
* If we are unable to offer a service that will meet your needs, we will do our best to refer or signpost you to a relevant alternative, where this is available.

**Help with the Form**:

* If you cannot fill in this form and would prefer an appointment, call us on 0191 283 2541.
* You could also ring our Duty Worker if you have a question.
* Or you could ask a friend or family member to help you.

**SECTION 2: CONFIDENTIALITY**

* All information you provide to the service is confidential. However, there may be times, when we have to share information:
  + If there is a risk of harm to you or others, including children
  + If there has or may have been a crime committed
  + If you inform us that you are currently or have in the past been abused or hurt by another person
  + If you are harming someone else
* Your notes are held securely on our database in line with NHS code of Practice.
* We routinely provide relevant information to your GP and other health and social care professionals where appropriate.  Please inform us if you would prefer that we did not share information with other professionals (however we will share information if there are concerns about safety as highlighted above).

|  |  |
| --- | --- |
| **Do you understand and agree with the above statements in Section 2?** | Yes / No  (delete as appropriate) |

|  |  |
| --- | --- |
| **Do you give us permission to forward this form to another mental health service if we think that they are better placed to help you?**  We would write to you to let you know. | Yes / No  (delete as appropriate) |

|  |  |
| --- | --- |
| If we need to contact you, are there any times Monday – Friday between 9.00am-5.00pm **that we are unlikely to be able to reach you**, and which number should we ring? |  |

**SECTION 3: PERSONAL DETAILS**

|  |  |
| --- | --- |
| **Title** | Mr / Mrs / Miss / Ms / Dr / Rev / Prof / MX  (Circle as appropriate) |
| **Pronouns (e.g. She/ Her, He/ Him, They/ Them, Ze/ Hir)** |  |
| **First Name** |  |
| **Preferred Name (if different from above)** |  |
| **Surname (Last Name)** |  |
| **Gender** | Male / Female / Non Binary / Other  (Circle as appropriate) |
| **Date of Birth** |  |
| **Home Address** |  |
| **Home Phone Number** | Home Phone Number:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Can we leave voice messages? Yes / No  (delete as appropriate) |
| **Mobile Phone Number** | Mobile Phone Number:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Can we leave voice messages: Yes / No  (delete as appropriate)  Can we send you appointment  reminders by text? Yes / No  (delete as appropriate) |
| **Please indicate if your referral is for Individual or couples Therapy.** | Individual Therapy Yes/No Couples Therapy Yes/No  For couples Therapy each person will need to complete their own assessment form**.** |

|  |  |
| --- | --- |
| **Name of the GP Practice you are registered with** |  |
| **Name of your GP** |  |

**In case of emergency contact**:

We ask all clients to provide an emergency contact number where possible to ensure your safety and wellbeing.

Do you give us permission to contact a family member/ friend/ carer in an emergency or if we have concerns about your wellbeing or safety? Yes/ No (delete as appropriate)

If Yes, please provide details below:

|  |
| --- |
| **Emergency Contact Information** |
| Name:  Relationship:  Telephone Number:  Address: |

**SECTION 4: DEMOGRAPHIC INFORMATION**

*If you do not wish to complete any of the following sections within the Demographic section, please leave them blank – double click the boxes to check box:*

|  |  |  |
| --- | --- | --- |
|  | | |
| **Disability Status** | No disability  Has disability  If yes, what is your disability?  Chronic Physical Illness  Hearing | Memory Loss  Mobility  Speech & Language  Vision  Other (please state below)  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Please tick if you have a diagnosed Learning Disability by the Learning Disabilities Team?** | | Yes  What is the diagnosis? |
| If you have said yes to the above, do you require any reasonable adjustments to help you attend and engage with therapy? | | Yes / No  If Yes please give details: |
| **National Identity** | English  Scottish  Welsh  **I**rish | British  Other (please state below)  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Ethnicity** | White British  White Irish  White Any Other Background  Mixed – White & Black Caribbean  Mixed – White & Black African  Mixed – White & Asian  Mixed – Any Other Mixed Background  Asian or Asian British – Indian | Asian or Asian British – Pakistani  Asian or Asian British – Bangladeshi  Asian or Asian British – Any Other Asian Background  Black or Black British – Caribbean  Black or Black British – African  Black or Black British – Any Other Black Background  Other Ethnic Groups – Chinese  Other Ethnic Groups – Any Other Ethnic Group |
| **Religion** |  | |
| **Is your preferred language English?** | Yes  No  If no, what is your preferred language? | |
| **Are you able to communicate in spoken English?** | Yes  No | |
| **Are you able to read and write in preferred language?** | Yes  No | |
|  | | |
| **Sexual Orientation** | Heterosexual (straight)  Homosexual (lesbian or gay) | Bisexual  Other |
| **Relationship Status** | Single  Married  Divorced  Widowed | Separated  Co-Habiting  Long Term  Civil Partnership |
|  | | |
| **Do you have any long term physical health conditions?** | Yes  No  If yes, what is your physical health problem?  Cancer  Chronic Pain  COPD / Asthma / Respiratory  Heart disease  Dementia | Diabetes  Epilepsy  IBS  Medically Unexplained  Symptoms  Stroke  Other (please state below) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Do you have any mobility or communication needs we should be aware of to ensure we can make any adjustments so you can access the service? If so, how can we help?** |  | |
|  | | |
| **Have you served for the British Armed Forces?** | Yes  No  If yes, what is your military number? | |
| **Are you a dependant of an ex-serving member of the British Armed Forces?** | Yes  No | |
|  | | |
| **Are you a full time carer for any adults?** | Yes  No | |
|  | | |
| **Are you or your partner pregnant?** | Yes / No  (delete as appropriate) | |
| **Do you have a child under the age of 2?** | Yes / No  (delete as appropriate) | |
|  | | |
| **Where did you hear about our service?** |  | |

**SECTION 5: ASSESSMENT**

**Why you have come to the Service:**

|  |  |
| --- | --- |
| What is the problem that you would like help with?  For example, worrying all the time, feeling depressed, can’t go out in public because I am scared of people judging me, scared to leave the house, panic attacks, flashbacks |  |
| How long have you had this problem? |  |
| Could you briefly describe why you think this problem might have started for you? |  |
| How is this affecting you now?  For example, how is it affecting your work, relationships, social life, sleep |  |
| Is your sleep affected?  If so you may be able to attend our Sleep Course, see section 8 for more information | Yes / No (delete as appropriate)  If yes, how is your sleep being affected? |

**Your Goals of Therapy:**

|  |  |
| --- | --- |
| What 3 positive changes would you hope to get from therapy (e.g. be more active, manage worry, improve sleep etc.) | 1.  2.  3. |

**Previous Treatment / Other Services Involvement:**

(We do not have access to previous medical treatment with other services)

|  |  |
| --- | --- |
| Are you currently getting help from any other mental health services? | Yes / No  (delete as appropriate) |
| If yes, who are you receiving support from and what type of support are you receiving? |  |
| Have you had help or treatment in the past for your mental health?   * What for? * What type of treatment? * Which service did you use? * When? * Did it help? | Yes / No (delete as appropriate)  If yes, please provide further details: |
| Are you involved with any other services?   * Which service? * Name of contact * Phone number | Yes / No (delete as appropriate)  If yes, please provide further details: |

**Family & Support:**

|  |  |
| --- | --- |
| Do you have children of your own under the age of 18? | Yes / No (delete as appropriate)  If yes, what are their full names and dates of birth?  Do they live with you?  Yes / No (delete as appropriate)  If they are not living with you are you still in regular contact?  Yes / No (delete as appropriate) |
| Are you responsible for any other child under age of 18? | Yes / No (delete as appropriate)  If yes, what are their full names and dates of birth?  Do they live with you?  Yes / No (delete as appropriate) |
| Are you aware of any of the children you have identified having been or are still in contact with Children’s Services? | Yes / No (delete as appropriate)  If yes, what is the name of the Social Worker involved and contact number?  Do you give us consent to contact them to share information about your care if necessary?  Yes / No (delete as appropriate) |

**If you are pregnant or have a child under 2, please answer the following questions:**

|  |  |
| --- | --- |
| Do you have any professionals involved in your care e.g. midwife, health visitor, obstetrician? | Yes / No (delete as appropriate)  If yes, what is their name, role and contact number?  Do you give us consent to contact them to share information about your care if necessary?  Yes / No (delete as appropriate) |
| Does anyone in your family have a history of mental health problems? | Yes / No / Unknown (delete as appropriate)  If yes, please provide further information if known |
| Do you have any diagnosed mental health problems? | Yes / No (delete as appropriate)  If yes, please provide further information |

**We have a duty of care to assess risk in order to prioritise people’s safety. The following questions are asked as standard to all clients and must be answered in full for the self-assessment to be progressed. If sections are incomplete then we will ring you to request further information.**

**Alcohol use** (if you do not complete this section we will need to ring you)**:**

|  |  |
| --- | --- |
| Do you drink alcohol? | Yes / No (delete as appropriate)  *If yes, please answer the questions below* |
| How much? |  |
| How often? |  |
| Do you think there is a link between your alcohol use and your mental health? If so, how? |  |
| Are you receiving any help for your alcohol use? | Yes / No (delete as appropriate)  If yes, who from? |

**Substance use** (if you do not complete this section we will need to ring you)**:**

|  |  |
| --- | --- |
| Do you use illegal drugs or legal highs? | Yes / No (delete as appropriate)  *If yes, please answer the questions below* |
| What do you use? |  |
| How much? |  |
| How often? |  |
| Do you think there is a link between your substance use and your mental health? If so, how? |  |
| Are you receiving any help for your substance use? | Yes / No (delete as appropriate)  If yes, who from? |

**Alcohol and drug use can lead to symptoms of depression and anxiety, if your use is to such an extent that we assess you need support from a drug or alcohol service before having talking therapies we will inform you.**

**If your primary problem is alcohol or drug use, then we would not be the most appropriate service to meet your needs and you should self-refer to Gateshead Recovery Partnership (was named Evolve) on 0191 594 7821.**

**Risk to yourself** (if you do not complete this section we will need to ring you)**:**

|  |  |
| --- | --- |
| I am currently experiencing thoughts of ending my own life or harming myself in some way | Yes / No (delete as appropriate)  If yes, please provide further details: |
| I have been thinking of ways to end my own life or harm myself in some way | Yes / No (delete as appropriate)  If yes, please provide further details: |
| I have plans to end my own life or harm myself in some way | Yes / No (delete as appropriate)  If yes, please provide further details:  **If you have answered yes to the above questions, our service does not offer urgent or crisis response services – please instead contact your GP, the Crisis Team on** **0191 814 8899, Samaritans on 116 123, or NHS 111** |
| What is positive in your life that helps to keep you safe and would stop you from harming yourself or ending your own life? |  |
| I have made attempts to end my own life in the past | Yes / No (delete as appropriate)  If yes, please provide further details including what happened, when this happened, and what led to this: |
| I am doing something to deliberately harm myself | Yes / No (delete as appropriate)  If yes, please provide further details including how you are harming yourself and what leads to this: |
| Do you have any financial problems that make you think ending your own life would be a solution? |  |
| Do you use the internet to search for ways to end your own life? |  |
| Are there any significant dates around loss of a loved one that would impact on your mental health? |  |

**Self-care** (if you do not complete this section we will need to ring you)**:**

|  |  |
| --- | --- |
| I am neglecting some of my basic needs  (Such as washing, dressing, eating, drinking, paying bills etc.) | Yes / No (delete as appropriate)  If yes, please provide further details: |

**Harm from others** (if you do not complete this section we will need to ring you)**:**

|  |  |
| --- | --- |
| Are you currently at risk of harm from other people? | Yes / No (delete as appropriate)  If yes, please provide further details: |

**Harm to others** (if you do not complete this section we will need to ring you)**:**

|  |  |
| --- | --- |
| Have you ever physically harmed another person? | Yes / No (delete as appropriate)  If yes, please provide further details: |
| Do you have any past convictions or police investigations about you causing harm to another person on-going? | Yes / No (delete as appropriate)  If yes, please provide further details: |
| Do you have a Probation Officer? | Yes / No (delete as appropriate)  If yes, what is the name of your Probation Officer and contact number?  We may need to request further information about your convictions from the police. Do you give consent for this?  Yes / No (delete as appropriate) |

**Additional Information**

|  |
| --- |
| Is there anything else you feel would be important for us to know at this point? (Please use the space below if needed) |

**SECTION 6: SYMPTOM QUESTIONNAIRES**

*Please mark the relevant answer to each question by placing ‘X in the appropriate column.*

**PHQ- 9**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | | **Not at all** | **Several days** | **More than half the days** | **Nearly every  day** |
| **0** | **1** | **2** | **3** |
| 1 | Little interest or pleasure in doing things |  |  |  |  |
| 2 | Feeling down, depressed, or hopeless |  |  |  |  |
| 3 | Trouble falling or staying asleep, or sleeping too much |  |  |  |  |
| 4 | Feeling tired or having little energy |  |  |  |  |
| 5 | Poor appetite or overeating |  |  |  |  |
| 6 | Feeling bad about yourself — or that you are a failure or have let yourself or your family down |  |  |  |  |
| 7 | Trouble concentrating on things, such as reading the newspaper or watching television |  |  |  |  |
| 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 |  |  |  |  |
| 9 | Thoughts that you would be better off dead or of hurting yourself in some way |  |  |  |  |

**GAD-7**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | | **Not at all** | **Several days** | **More than half the days** | **Nearly every  day** |
| **0** | **1** | **2** | **3** |
| 1 | Feeling nervous, anxious or on edge |  |  |  |  |
| 2 | Not being able to stop or control worrying |  |  |  |  |
| 3 | Worrying too much about different things |  |  |  |  |
| 4 | Trouble relaxing |  |  |  |  |
| 5 | Being so restless that it is hard to sit still |  |  |  |  |
| 6 | Becoming easily annoyed or irritable |  |  |  |  |
| 7 | Feeling afraid as if something awful might happen |  |  |  |  |

**Work and Social Adjustment Scale**

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.

If you are retired or choose not to have a job for reasons unrelated to your problem, please tick here

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Not at all |  | Slightly |  | Definitely |  | Markedly |  | Very severely |

|  |  |
| --- | --- |
| 1. **WORK** 2. Because of my problem my **ability to work** is impaired |  |
| 1. **HOME MANAGEMENT** 2. Because of my problem my **home management** (cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc.) is impaired |  |
| 1. **SOCIAL LEISURE ACTIVITIES** 2. Because of my problem my **social leisure activities** (with other people, e.g. parties, pubs, outings, entertaining etc.) are impaired |  |
| 1. **PRIVATE LEISURE ACTIVITIES** 2. Because of my problem my **private leisure activities** (done alone, e.g. reading, gardening, sewing, hobbies, walking etc.) are impaired |  |
| 1. **FAMILY AND RELATIONSHIPS**   Because of my problem my ability to **form and maintain close relationships** with others including the people that I live with,is impaired |  |

**Phobia Scales**

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Would not avoid it |  | Slightly avoid it |  | Definitely avoid it |  | Markedly avoid it |  | Always avoid it |

|  |  |
| --- | --- |
| Social situations due to a fear of being embarrassed or making a fool of myself |  |
| Certain situations because of a fear of having a panic attack or other distressing symptoms (such as loss of bladder control, vomiting or dizziness) |  |
| Certain situations because of a fear of particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying). |  |

**SECTION 7: EMPLOYMENT & MEDICATION**

**Employment:**

|  |  |  |
| --- | --- | --- |
| **Tick one which applies to you** | Work full time / over 30 hours  Work less than 30 hours  Unemployed (no benefits)  Full time student  Retired  Full-time homemaker / carer | Long term sick or disabled (and  claiming benefits)  Not receiving benefits but not  looking for work  Unpaid voluntary work who are  not looking for work |
| **Tick if you are receiving any of these benefits** | Statutory Sick Pay  Job seekers Allowance  Income Support  Universal Credit | ESA  Personal Independence Payment  (PIP) |

|  |  |
| --- | --- |
| Are you currently employed by South Tyneside and Sunderland NHS Foundation Trust? | Yes / No |

**Medication:**

|  |  |
| --- | --- |
| **Do you take any prescribed medication for your mental health?** | Yes / No (delete as appropriate)  If yes, what is your medication and what is the dosage?  If yes, how long have you been taking the medication for?  Are you taking the medication as prescribed? |
| **Do you take any other prescribed medications?**  **(e.g. for pain etc.)** | Yes / No (delete as appropriate)  If yes, what is your medication and what is the dosage?  If yes, how long have you been taking the medication for? |

**If you are age 16 or 17**

We work closely with the Emotional Wellbeing Team in Gateshead, who also work with 16 and 17 year olds. We discuss all new referrals of 16 and 17 years olds in a regular meeting to make sure you are offered the right service for you.   
  
To help support this decision process please can you answer the following:

|  |  |
| --- | --- |
| **If you are still in education what is the setting?** | School  College  Apprenticeship |
| **What would your service preference be for treatment?** | Gateshead Talking Therapies  Emotional Wellbeing Team  No preference  Reason…………………………………………………………………. |

You will receive a letter after the meeting to advise you of the outcome of your referral, and if appropriate, which service waiting list you have been added to.

**SECTION 8: TREATMENT OPTIONS**

**The service offers a variety of evidenced based treatments, our therapists will recommend the most appropriate treatment based on the information you have included above.**

**How do we deliver treatment?**

We offer telephone, video and face to face sessions, both in groups and in an individual setting. All sessions would be conducted in confidential environments.

Video therapy involves us sending you a link via email or SMS (with your consent), you click on the link (no software download necessary), and you have a live session with your therapist who you can see and speak to. You would need access to the internet via laptop/computer or smart phone to be able to access this. Research and experience is showing us that video therapy gets the best outcomes as it is a personal approach, which also takes less time from your weekly schedule and helps appointments be attended more regularly.

Some people prefer telephone options as this offers a personal connection, again with increased flexibility.

We do have face to face appointments available and can provide these (in a range of venues across Gateshead) if required.

You are likely to receive a quicker appointment if you are flexible in how and when your appointments are delivered. Whilst we try to accommodate preferences, sometimes this can lead to delays in treatment.

**Virtual or face to face Groups and Courses.**

We offer a range of courses to help people understand more about their difficulties and work on coping strategies to improve their mental health. These may be delivered on a video platform (as above) or in person.

Where we feel like a group/course will be helpful in your treatment, we will recommend this to you and will send you all the relevant information on how to access the groups/courses closer to the start of the course.

Groups and courses are a great way of recognising you are not alone in your difficulties. People only share details that they want to (no pressure to share your personal details) and can learn lots from others experiences. Courses run frequently so you are likely to get help sooner if you attend a course.

Some of our courses can be attended alongside individual therapy.

Feedback from previous clients has indicated they left the sessions feeling as if they are not alone and they learnt more from being in a group/course.

“I am so pleased I attended my first group therapy, especially since I had initially refused as I believed it would be too traumatic to be around other people, I won't pretend it was easy.  I found it comforting to be around people who experienced the same thoughts and fear as myself and have learned a great deal from the therapists and others in the group.”

**The courses we currently have running are:**

|  |
| --- |
| **Take Control of Anxiety (5 weeks)**  Learn about what anxiety is, how it affects our bodies and coping strategies to start to manage and overcome anxiety. |
| **Sleep Course (3 weeks)**  Find out about good bedtime routines, what can get in the way of good sleep, and tips to sleep better. This can be attended alongsid a 1:1 intervention. |
| **Increasing motivation and mood (6 weeks)**  Find out more about what’s getting in the way of your motivation, and keeping your mood low. Learn strategies and receive support to start to build up your activities and feel better in yourself. |
| **Overcoming worry (8 weeks)**  Work with a group to learn more about how we worry, what keeps worry going and develop skills to manage this more effectively. |
| **Mindfulness (8 weeks)**  Receive support to engage in Mindfulness; meditation practice, focus on the here and now, reduce judgement, and allow yourself to be in the present. |
| **Mum’s Talk**  **Postnatal Mental Health Course (8 weeks)**  This group is for new Mum’s with babies up to 2 years old. It is set in a baby group environment and is a very supportive group to reflect and develop ways to look after yourself in your role as a parent. Babies can be brought along until they are mobile. |

|  |  |
| --- | --- |
| Do you have access to a computer / laptop / tablet which has a camera on it and access to the internet? | Yes  /  No  (delete as appropriate) |

**We also have other methods of providing treatment, please select which ones you may be willing to consider, you can say yes to more than one:**

|  |
| --- |
| **Internet therapy** (internet connection required)  You receive access to an evidence based online programme which you can complete at your own convenience. You would learn about mood, motivation and overcoming depression. You would also receive weekly 15 minute telephone support calls from a practitioner to review and support you with your progress.  Yes / No (delete as appropriate) |
| **Virtual Reality Therapy**  If there is a specific phobia or fear that you are trying to overcome, or common situations that cause you anxiety – we could offer treatment using innovative technology though Virtual Reality alongside a trained therapist.  Yes / No (delete as appropriate) |
| **Low intensity Cognitive Behavioural Therapy**  Work with one of our Psychological Wellbeing Practitioners on a 1:1 basis. This would involve 30 minutes appointments over a maximum of 6 weeks. They work with a range of anxiety and depression presentations, provide details and resources of managing your difficulties, and support you in your recovery.  Yes / No (delete as appropriate) |
| **Couples therapy for Depression**  This is a therapy involving people in a romantic relationship and both individuals would need to be willing and consent to be involved. Work with a therapist to identify difficulties and work together to improve communication and strengthen your relationship.  Yes / No (delete as appropriate) |
| **One to one psychological therapy**  We offer a range of one to one therapy options using a range of evidence based treatments. All one to one therapy aims to working together with you to identify current unhelpful patterns and support you to make positive changes for the future.  Yes / No (delete as appropriate) |

|  |
| --- |
| **If you have a strong preference for a specific type of therapy please give us details below:**  If you have any questions let us know and we would be happy to provide further details. |

|  |  |
| --- | --- |
| We have male and female therapists working from 9am to 8pm Monday to Thursday and 9am to 5pm on Friday.    We will offer you the next available appointment.  Would you have any difficulties with this?    The less availability you provide the more difficult it will be to allocate you a timely appointment.    You will be seen quicker if you are flexible about when you can come to appointments. |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Your name / signature: |  | Date: |  |

**SECTION 9: RETURNING YOUR FORM**

|  |  |
| --- | --- |
| **Date you completed the form:** |  |

You can either post your form to:

Gateshead Talking Therapies

The Croft

Springwell Road

Wrekenton

NE9 7BJ

OR this can be emailed to a central email address: [stsft.thecroft@nhs.net](mailto:stsft.thecroft@nhs.net) However you need to be aware of the possible risks of emailing confidential information:

* The Trust cannot guarantee the security of any email you send to the above address
* Communication to this address is entirely at your own risk
* You will receive an automated email confirmation that we have received your form
* After the information has been added to our electronic system it will be disposed of securely

**Please note that if you return your form to us via email then this will give us your consent to contact you using the email address you use to contact us.**

**If this consent is not provided, please ensure to highlight this on the form or return via post.**