**Patient Referral Form** 

Please complete this referral with the required information and return **by email** to the Digital Interventions Team:**SILVERCLOUDcbt@nhslothian.scot.nhs.uk** **| Contact us on 0131 537 1247 if you require any immediate assistance.**

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| PATIENT DETAILS FOR REFERRAL: Silvercloud *requires* an email to securely generate a link for patients to access treatment.Please note that any email or phone contact details provided will be used to send information related to cCBT to the patient, including access details and courtesy telephone calls by the support team. Patients will have 4 weeks to activate via email link, with a call and letter sent at 2 weeks to prompt activation. |
| Name:Click here to enter name | **CHI:** (please provide full CHI and not just DOB where possible)Click here to enter CHI number |
| Telephone: (mobile preferred below)Click here to enter contact number | **Email:** (this is **REQUIRED** - if no email available we cannot provide access to treatment)Click here to enter EMAIL, inform patient they will be emailed the NEXT WORKING DAY |
| Address: Click here to enter ADDRESS IF DIFFERENT FROM TRAK |
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| **Main Silvercloud programme modules** *Please select* ***one*** *treatmentPatients can only be referred for one cCBT treatment at a time (including the Beating the Blues/IESO)*       **Progress is reviewed every 3 weeks (*2 weeks for Perinatal*) from referral being processed,(to a maximum of ~15 weeks) to capture clinical information and encourage patient engagement.On completion of the review process patients have access to all content/tools up to 12 months from registration.** |
| *Please contact the team for further information regarding the module content of each treatmentor if you would like to access a demo version of any of these treatments to view the website yourself.* |

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| Referrer Name/Clinical Contact: (indicate if we should contact another clinician/shared inbox for updates including alert information below) |
|  | Click here to enter any ADDITIONAL information regarding the clinical contact in the event of an alert – for example: ‘email teamadmin@’ or ‘contact Duty GP at Surgery’ |
| Date of referral: | **Telephone:** | **Email:** | **Address/Location:** |
| Click here to enter date | Click here to enter clinical contact number |  | Click here to enter clinical contact address/location for reporting of clinical updates for patient |
| Reason for referral/relevant information (Free text):  |