

**NHS Transition, Intervention and Liaison veterans'  
Mental Health Service (TILS)  
South West and South Central Service referral form  
Please complete all sections of form**

| Personal   |                     | Military   |             |
|--|---------------------|--|-------------|
| Full name  |                     | Service Number if known                                  |             |
| Date of birth  |                     | Service  |             |
| NHS Number   |                     | Rank   |             |
| NI Number  |                     | Unit   |             |
| Gender   |                     | Trade  |             |
| Ethnicity  |                     | Joining up date  |             |
| Current Address  |                     | Discharge date   |             |
|  |                     | Referral   |             |
|  |                     | Self referral (please tick) _____                        |             |
|  |                     | Referrers name   |             |
| Postcode   |                     | Rank / Title   |             |
| Telephone  |                     | Relationship to service person                           |             |
| Mobile   |                     | Address  |             |
| Email  |                     | Postcode   |             |
| Disability   |                     | Telephone  |             |
| None _____   | Mental Health _____ | Mobile   |             |
| Not disclosed _____  | Physical _____      | Email  |             |
| Other _____  | Sensory _____       | Please confirm consent to refer to our service: yes / no | Yes      No |
| If other, please describe  |                     | GP   |             |
| Planned Change of Address/ Discharge Details (if leaving forces) |                     | GP Name  |             |
| Address  |                     | Practice name  |             |
| Postcode   |                     | Address  |             |
| Telephone  |                     | Postcode   |             |
| Next of kin  |                     | Other services involved, brief details                   |             |
| Title  |                     | DCMH   |             |
| Name   |                     | PRU  |             |
| Relationship   |                     | Local Authority  |             |
| Address  |                     | NHS  |             |
| Postcode   |                     | Third sector   |             |
| Telephone  |                     | Charities  |             |

**REASON FOR REFERRAL, PRESENTING PROBLEMS HELP AND SUPPORT CLIENT WOULD LIKE FROM THE SERVICE**

*If possible please include: the nature of the problem; triggers; time of onset and the clients view of what they want help with.*

Reason for discharge:

ICD-10 code:

**RISK ISSUES - the following sections below must all be completed**

*Please provide as much detail as possible regarding risk to self and/or others, AND any safeguarding issues. Do not leave blank. Put 'no current evidence identified or expressed' if no answer.*

Risk to self:

Risk **from** others:

Risk **to** others:

Forensic:

Safeguarding  
issues / concerns:

**Current alcohol or illicit substance use:**

*please consider referral to substance misuse services if this is the primary presentation*

**Current medication:**

**OTHER ISSUES TO BE CONSIDERED**

(Other factors, such as physical health, finance, accommodation, legal)

When complete, please email this referral form to [gateway@berkshire.nhs.uk](mailto:gateway@berkshire.nhs.uk)

Any questions please call us 0300 365 2000 (Option 4)

Visit our website [www.berkshirehealthcare.nhs.uk/veterans-tils](http://www.berkshirehealthcare.nhs.uk/veterans-tils)