COMPLEMENTARY THERAPY FORM

YOUR INFORMATION (IF DIFFERENT TO PATIENT)

First Name

Last Name

Address and Postcode

Phone Number

Relationship to patient

PATIENT INFORMATION

First Name

Last Name

Address and Postcode

Phone Number

Date of birth

NHS number

Reason for referral

Diagnosis, medications and date diagnosed

Are there other health professionals involved in their care? YES N If yes, please give details

Do they have any communication difficulties? YES N If yes, please give details

Are there any safety or mental health concerns? YES N If yes, please give details

Do they have any mobility issues? YES N

Do they have an Advanced Care Plan? YES N DON'T KNOW

Do they have a DNAR in place? YES N DON'T KNOW

Reason for referral:

Relaxation Stress Anxiety Low mood Pain Nausea Insomnia

Well-being Psychological distress Fatigue Well-being Muscular Tension