Stressmottagningen

PERSONAL REFERRAL

Date:
First name and surname:
Personal number (YYMMDD-XXXX):
Telephone/mobile:
Address:
Do you need an interpreter? ☐ No ☐ Yes, which language:
What kind of rehabilitation are you looking for? ☐ Exhaustion syndrome ☐ Long lasting, chronic pain ☐ Combination of both
Are you employed or studying? Full or part-time?
Are you signed off sick? How much and since when?

Your current health

Have you consulted a General Practitioner regarding your current health? ☐ No ☐ Yes, please summarise which investigations have been carried out, results and which diagnoses the doctor has set: Do you believe your issues have been fully investigated?
What medicines (if any) are you taking?
Which of the following apply to you? (put an x in the box for each that apply) ☐ physically tired ☐ mentally tired ☐ difficulties with concentration ☐ memory issues ☐ difficulty handling demands and deadlines ☐ difficulty making sense ☐ pain ☐ dizziness ☐ noise sensitive ☐ feeling low ☐ depression ☐ worried ☐ anxiety ☐ panic attacks ☐ PTSD (trauma-related anxiety) ☐ ADD/ADHD ☐ autism
Which of your symptoms do you feel affect you most? 1. 2. 3.
Summarise what you believe has caused your ill-health and how your problems developed:
Do you authorise us to be able to read your medical notes in Take Care (a Swedish medical notes system) (put an x in the relevant box) ☐ YES ☐ NO

Town, date: _____ Signature: _____

We will get in contact should we have any further questions.

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