Hertfordshire Partnership NHS
University NHS Foundation Trust

Wellbeing Service Client Service Receipt Inventory (CSRI)

Are you completing this questionnaire (please select one):

- ☐ Before you start your treatment with IAPT
- ☐ Immediately after you have completed your treatment with IAPT
- ☐ Sometime after completing your treatment with IAPT

1. **<u>In the last 3 months</u>, what face-to-face appointments have you had with health professionals outside of the IAPT therapy service?** (Please note: only record one-to-one contacts here; see next questions for A&E)

Care provider	Have you seen any of the following healthcare professionals in the last 3 months? (Circle)	Usual location (please answer using one of the following numbers: 1 = GP practice 2 = Community centre 3 = Hospital outpatient 4 = Own home)	Number of contacts in the last 3 months	Reason for attending
General practitioner (GP)	Yes or No			
Practice nurse	Yes or No			
Physiotherapist	Yes or No			
Occupational therapist (OT)	Yes or No			
Specialist nurse (e.g. cardiac nurse, diabetes nurse)	Yes or No			
Doctor other than GP for a physical health problem (e.g. cardiologist, gastroentologist, oncologist)	Yes or No			
Podiatrist	Yes or No			
Social worker	Yes or No			
Drug & alcohol adviser	Yes or No			
Other counsellor/therapist/clinical psychologist (outside of the IAPT service)	Yes or No			

Home treatment/crisis team/assertive outreach/community mental health team, e.g. psychiatrist, mental health nurse (CPN)	Yes or No			

2. **<u>In the last 3 months</u>, how many times have you attended accident and emergency (A&E)?**

……..

3. **<u>In the last 3 months</u>, have you been admitted to hospital as an inpatient?** Yes **or** No

……..

If yes:

Name of hospital	Reason for admission	How many days were you in hospital?	Do you recall the admission date?

4. **<u>In the last 3 months</u>, have you needed to call an ambulance?** Yes **or** No

5. **<u>In the last 3 months</u>, have you had any of the following investigations or diagnostic tests?**

Type of test	Have you had this test? (Please circle one)	Number of investigations/tests in the last 3 months
MRI Scan	Yes **or** No	
CT/CAT Scan	Yes **or** No	
Ultrasound	Yes **or** No	
X-Ray	Yes **or** No	
EEG	Yes **or** No	
Blood test	Yes **or** No	

6. **Are you in paid employment?** Yes **or** No
   If yes, how many days have you had off due to ill health in the last 3 months? ……..

Thank you for taking the time to complete this.