C-A-439 Referral Form

Name & Position of Referrer				**Date of Assessment**		
Service(s) for Referral/Admission (if identifying more than 1 service please enter in preference order)						
SOURCE OF REFERRAL						
Organisation Name						
Organisation Address						
Current Consultant Psychiatrist						
Telephone No.		Fax No.				
Email						
FUNDING RESPONSIBILITY						
Contact Name						
Funder Address						
Telephone No.		Fax No.				
Email						
REFERRAL EXPECTATIONS						
How urgent is this referral (Please circle)	Routine		Urgent			
Required/Expected Admission Date						
Expected Duration of Admission/Stay						
How did you hear about us? (please circle)	Brochure	Word of Mouth	Website	Previous referral		
SERVICE USER						
Name		Date of Birth				
Current Placement		Nationality				
		Ethic Origin				
		Sexual Orientation (Please circle as identified)				
Telephone No.		Heterosexual	Asexual	Bisexual	Homosexual	Declined to say
MHA Status						
Diagnoses				Classification		
Reason for referral						
Name of Next of Kin			Tel. No.			
Address of Next of Kin						
Relationship		Is Next of Kin aware of referral		Yes	No	
Name & Address of GP						
			Tel. No.			
Background Information						
Psychiatric History						
Forensic History						

Physical Health/Disabilities
Current Presentation
Current Medication
Protective Factors

Enhanced observation level currently required		Yes	No	**If Yes, Please complete below**
Period / Venue / Activity	**No of Hours**	**Observation Level (1:1/2:1, etc.)**		**Staff Grade**
Day time				
Night time				
Community				
Other (Specify below)				

Clinical rationale for enhanced observation (if identified other above, specify requirement below i.e. home leave)		
Current Enhanced observation level to continue on Admission	Yes	No
If NO, response to above, identify Enhanced Observation Level that will be required on Admission.		

Short Term Aims
1.

Long Term Aims
1.

Staff Training Requirements to Support Admission		
When is this training required (Please circle)	Before Admission	After Admission

Environmental Requirements to Support Admission		
When are environmental changes required (Please circle)	Before Admission	After Admission

Other Specific Requirements to Support Admission (Describe requirement & whether required before/after admission)

MDT Assessments Required for First 10 Weeks Post Admission		
MDT Member	**Need**	**Assessment**
Psychiatry		
Psychology		
Nursing		
Occupational Therapy		
S&L Therapy		

Referrer Signature		**Date**	

Please return completed Referral form to the Regional Relationship Manager along with supporting documents such as latest assessments and CPA reports to enable a timely decision to be reached on whether to progress to a preadmission assessment