

<b>SURNAME</b>		<b>OTHER NAMES:</b>		<b>REFERRAL DETAILS</b>			
<b>Date of Birth:</b>		<b>Age:</b>		<b>By:</b> .....			
<b>Title:</b> M/S/W/D/SEP		<b>M/F</b>		<b>Profession:</b> .....			
<b>Ethnic Origin and Religion:</b>				<b>Address:</b> .....			
<b>Preferred Language:</b>				<b>Tel No:</b> .....			
<b>Lives alone?</b>		<b>Yes / No</b>		<b>Route:</b> .....			
<b>ADDRESS:</b> ..... ..... ..... ..... ..... .....				<b>Date and time:</b> .....			
<b>TEL:</b> .....				<b>Taken by:</b> .....			
<b>NEXT OF KIN:</b> .....				<b>G.P. NAME:</b> .....			
<b>RELATIONSHIP:</b> .....				<b>PRACTICE:</b> .....			
<b>TEL:</b> .....				<b>TEL:</b> .....			
<b>CURRENTLY IN EMPLOYMENT?</b> Yes/ No/ Don't Know				<b>PROFESSIONALS INVOLVED:</b> .....			
If "Yes": <b>FULL TIME / PART TIME</b>				<b>TEL:</b> .....			
				<b>TEL:</b> .....			
<b>CURRENT CARE INPUT/PACKAGE:</b> (from Health Service, Social Services, family and others) ..... ..... ..... .....				<b>DATE last seen by GP:</b> .....			
<b>CURRENT MEDICATIONS:</b>				<b>CARER'S NAME:</b> .....			
				<b>RELATIONSHIP:</b> .....			
				<b>TEL:</b> .....			
				<b>KNOWN PHYSICAL HEALTH PROBLEMS:</b>			

**REASONS FOR REFERRAL: (as much detail as possible, including duration of problem)**

Is client aware of this referral? Yes / No .....

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**If low mood/depression: - Has the person been treated with antidepressants: Yes/ No/ Don't Know**

If "Yes", when commenced? ..... When finished? (If applicable) .....

**If person is confused/has memory problems: - Have they been assessed by their GP? Yes/ No/ Don't Know**

Have blood-screening tests been done? Yes/ No/ Don't Know

Have any other physical investigations been done? E.g. Urine, chest x-ray. Yes/ No/ Don't Know

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**Any other psychiatric symptoms – e.g. Anxiety, agitation, hallucinations, delusions? Yes/ No/ Don't Know**

If "Yes" give details: .....

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**Any substance/ alcohol misuse? Yes/ No/ Don't Know**

If "Yes" give details: .....

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**Any child protection issues/ history? Yes/ No/ Don't Know**

If "Yes" give details: .....

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**Previous Psychiatric History** Yes / No / Don't Know

**Previous Mental Health diagnoses:** .....

**Section 117 aftercare?** Yes / No / Don't Know

<b>CRITERIA FOR PRIORITY</b>			
<b>Has this client ever:</b>	Yes (Y) No (N) Don't Know (DK)	<b>Is this client currently:</b>	Yes (Y) No (N) Don't Know (DK)
Expressed suicidal ideation?	Y / N / DK	Expressing suicidal ideation?	Y / N / DK
Had episodes of self harm?	Y / N / DK	Deliberately self harming?	Y / N / DK
Had a history of violence/ aggression?	Y / N / DK	Behaving with violence or aggression towards others?	Y / N / DK
Had a history of inappropriate sexual behaviour?	Y / N / DK	Behaving sexually inappropriate?	Y / N / DK
Details: .....		A risk to themselves?	Y / N / DK
.....		A risk to others?	Y / N / DK
.....		Details: .....	
.....			

Boxes below are for completion by duty worker/team leader only

*Using criteria, referral is* **URGENT / NON-URGENT\*** \*delete as applicable

**FOR CHECKING BY DUTY WORKER/ TEAM LEADER (after taking referral):**

Is this person a current or previous client of Mental Health Services Yes / No

If "Yes", give name of Care Co-ordinator: ..... current / previous give date .....

Is there previous or current contact with a psychiatrist? Yes / No

If "Yes", give name of Psychiatrist: .....

Date of last/next appointment: .....

**OUTCOME OF REFERRAL/ALLOCATION:**

Passed back to referrer? Yes / No Give reason: .....

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Accepted Yes / No

Allocated to: ..... Designation: .....

Reason for allocation to this worker: .....

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**ALLOCATION RECORDED BY: Name:** ..... **Date:** .....

Psychiatric case notes requested from Medical Records/Consultant's secretary?  (Tick when requested)