Patient Referral Form
Men's Service

Directorate of Strategic Development & Marketing

Please complete all sections and return form to
St Andrew's Admissions Service fax: 01604 603218

REFERRER'S DETAILS	
DATE: (dd/mm/yy)	CONTACT ADDRESS: Postcode:
NAME OF REFERRER:	
NAME OF ORGANISATION:	
CONTACT PHONE NO:	EMAIL ADDRESS:

PATIENT'S DETAILS		
FULL NAME: (please print)		
DATE OF BIRTH: (dd/mm/yy)		CURRENT AGE:
MARITAL STATUS:	ETHNIC GROUP:	PATIENT'S 1ST LANGUAGE
PATIENT'S LAST KNOWN HOME ADDRESS: Postcode:		
NHS NUMBER: (compulsory)	SOCIAL SERVICES IDENTIFICATION NUMBER:	
YEAR OF FIRST MENTAL HEALTH TREATMENT:		
LAST KNOWN GP's NAME:	GP's ADDRESS: Postcode:	
GP's CONTACT PHONE NO:		

DETAILS OF PATIENT'S CURRENT PLACEMENT	
ORGANISATION NAME:	ORGANISATION ADDRESS: Postcode:
CONTACT NAME:	
PHONE NUMBER:	

FUNDING – (who will fund the placement at St Andrew's Healthcare?)	
PCT / TRUST NAME:	
CONTACT NAME:	CONTACT PHONE NUMBER:
CONTACT ADDRESS: Postcode:	
Please ensure that you have informed the PCT / Trust of this Referral	

LEGAL STATUS		
INFORMAL: Yes / No	SECTION:	MENTAL CATEGORY:

PLEASE LIST BELOW ANY PROFESSIONALS INVOLVED IN THE PATIENT'S CARE i.e. Clinical Lead, CPN, Social Worker			
Name	Designation	Address	Contact phone number
	CPA CARE CO-ORDINATOR		

SUMMARY OF DIAGNOSIS / MAIN PROBLEMS					
Please tick:					
Learning Disability: Mild / Moderate / Severe (please indicate)				Mental Illness	
Acquired Brain Injury		Huntington's Disease		Personality Disorder	
Please give details:					

*****PLEASE ATTACH ANY SUPPORTING REFERRAL DOCUMENTATION*****
i.e. Psychiatric Reports, Risk Assessment reports, Mental Health Tribunal reports

IS THERE ANY OTHER RELEVANT INFORMATION eg chronic physical illness/handicaps?

PLEASE ADVISE IF THE PATIENT HAS BEEN REFERRED TO ANY OTHER ORGANISATION
NAME OF ORGANISATION: 1. 2. 3.

REASON FOR REFERRAL (please tick relevant boxes below)			
No local NHS facility available		Secure bed required	
Local NHS facility is full		Cost of bed	
Specialist Service offered at St Andrew's		Location	
St Andrew's Reputation / Recommended		Emergency bed required	
If there is any other reason for the referral, please state:			

* This information will be held securely under the Data Protection Act. The information will not be released without further consent from the originating organisation. Your details will be held in a database and may be used for marketing purposes by St Andrew's Healthcare. If you object to us sending you details of our services, please tick here: ☐

NEXT OF KIN:	
ADDRESS	
NEAREST RELATIVE (for purposes of Mental Health Act)	
ADDRESS	
MAIN CONTACT PERSON(if different from next of kin)	
ADDRESS	

CPA REVIEWS	
Date of last CPA Review	
Date of next CPA Review	

PATIENT'S VIEW OF REFERRAL

FAMILY/CARER'S VIEW OF REFERRAL

RISK AND PROBLEM BEHAVIOURS

	Past	Current
Risk to Self		
Risk to Others		
Sexual Offending		
Arson		

CLINICAL DETAILS

Past Psychiatric History

Past Treatments (pharmacological, psychological and other)

MEDICAL HISTORY

DEVELOPMENTAL AND PERSONAL DETAILS

FAMILY DETAILS

EDUCATIONAL AND OCCUPATIONAL DETAILS

PSYCHOSEXUAL DETAILS

FORENSIC HISTORY (if not covered in risk details)(please attach any criminal records etc)

ALCOHOL AND ILLICIT SUBSTANCE USE

CURRENT MENTAL STATE

CURRENT MEDICATION

CURRENT INTERVENTIONS eg psychological, ot, nursing

Any comments that you may have regarding this form, in particular its ease of completion, would be appreciated. Please make your comments on the back of page 7.

Thank you for completing this referral form.