

Patient Referral Form

Men's Service



St Andrew's
HEALTHCARE

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:
NAME OF REFERRER:	
NAME OF ORGANISATION:	Postcode:
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 1 ST 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:	
GP's CONTACT PHONE NO:	Postcode:	

DETAILS OF PATIENT'S CURRENT PLACEMENT

ORGANISATION NAME:	ORGANISATION ADDRESS:
CONTACT NAME:	
PHONE NUMBER:	Postcode:

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.