

Patient Referral Form

Townsend Service



St Andrew's
HEALTHCARE

**Please complete all sections and return form to
the Townsend 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)		
MALE / FEMALE (delete one)	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 G.P.'s NAME:	G.P.'s ADDRESS:	
G.P.'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	<input type="checkbox"/>	Secure bed required	<input type="checkbox"/>
Local NHS facility is full	<input type="checkbox"/>	Cost of bed	<input type="checkbox"/>
Specialist Service offered at St Andrew’s	<input type="checkbox"/>	Location	<input type="checkbox"/>
St Andrew’s Reputation / Recommended	<input type="checkbox"/>	Emergency bed required	<input type="checkbox"/>

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:

November 2006

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	

PATIENTS VIEW OF REFERRAL

FAMILY/CARERS 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

Has this patient been subject to a Multi-Agency Public Protection Panel Arrangement referral or meeting?

Current Mental State

Current Medication

Current Interventions eg psychological, OT, nursing