

# Patient Referral Form

## Women'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 <sup>ST</sup> 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  
ie 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:

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

<b>CPA REVIEWS</b>	
<b>Date of last CPA Review</b>	
<b>Date of next CPA Review</b>	

<b>PATIENT'S VIEW OF REFERRAL</b>

<b>FAMILY/CARER'S VIEW OF REFERRAL</b>

<b>RISK AND PROBLEM BEHAVIOURS</b>		
	<b>Past</b>	<b>Current</b>
<b>Risk to Self</b>		
<b>Risk to Others</b>		
<b>Sexual Offending</b>		
<b>Arson</b>		

<b>CLINICAL DETAILS</b>	
<b>Past Psychiatric History</b>	
<b>Past Treatments (pharmacological, psychological and other)</b>	

**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.*