Patient Name:	
Date of Referral:	

Inpatient referral form

Before completing this form, please contact our admissions team for the latest bed availability and process guidance. When advised to do so, please complete this form, Save as, and then send as an email attachment with accompanying information directly to SAH.admissions@nhs.net

Admissions team	
Available Monday-Friday 8:30am - 5:30pm	**Telephone:** 0800 434 6690
	Email: SAH.admissions@nhs.net

St Andrew's Service required		Security level required	

Patient Details			
Name		Patient diagnosis	
NHS Number		Current placement	
Gender		Date of admission to current placement	
Date of birth		Current placement contact name	
First language		Current placement telephone	
Religion		Legal status	
Ethnicity		Date of detention	
Patient home address			
Specific communication considerations			

Important Contact Details			
Guardian/Nearest Relative name		Telephone	
Current Responsible Clinician name		Telephone	
GP name + clinic		Telephone	
Care Coordinator name		Telephone	
Social Worker name		Telephone	
Bed Manager name		Telephone	

Referrer Details			
Referrer name		Telephone	
Organisation		Email	

Patient Name:	
Date of Referral:	

St Andrew's HEALTHCARE

Authorisation/Commissioning Details

Organisation responsible for funding			
Telephone		Email	

I confirm that I have the delegated authority to authorise this episode of treatment on behalf of the funding authority. I understand and agree that all accepted referrals would be subject to St Andrew's Healthcare Inpatient Terms in force during the patient's inpatient stay. The current version of these terms is available at www.stah.org/making-a-referral or on request.

Name		Digital signature	
Telephone			

Please note: For all admissions, we will also require a signed Named Patient Agreement, which will be sent to you from our admissions team. Enhanced support or escorted nursing is not included in the daily bed rate. For these fees please contact our admissions team on 0800 434 6690.

Reason for referral

Please provide your reason for referring this patient and what specific outcomes you are looking for.

2 lines

To allow us to make a clinical decision please aim to provide the following patient information:

- Background history
- Psychiatric history
- Medical history (incl. allergies and drug reactions)
- Drug and alcohol history
- Current medication and care provided
- Social history, incl. current significant relationships
- Risk history
- Physical health and mobility needs

This information can be supplied by sending the following patient documents with this referral form.
Please tick the information you have included.

- ☐ Psychiatric report
- ☐ Patient Risk Assessment including risk/incident logs
- ☐ Manager's hearing report - Psychiatric and Social Work
- ☐ Mental Health Tribunal report - Psychiatric and Social Work
- ☐ Gatekeeping assessment
- ☐ Discharge summaries
- ☐ List of current medications including PRN
- ☐ Current care plan
- ☐ Forensic summary
- ☐ CPA reports

Please detail any other information available which could help us to make a clinical decision.

6 lines

Thank you for your referral. Please email all information direct to our admissions team who will contact you shortly.

Signature of this referral form is taken as an acceptance of our Terms of business.
To view our full Terms visit www.stah.org/making-a-referral

Save