

Patient name: 

 Date of referral: 

# Psychiatric Intensive Care (PICU) and acute inpatient referral form

Please send your referral with supporting clinical documentation to:

 [sah.picuacute@nhs.net](mailto:sah.picuacute@nhs.net)

If you wish to discuss a referral with someone over the phone, please call the enquiry line:

 **0800 434 6690**

## Service required

 Male PICU 

 Male Acute 

 Female Acute 

## Patient details

Name <input type="text"/>	Patient diagnosis <input type="text"/>
NHS number <input type="text"/>	
Gender <input type="text"/>	Legal status <input type="text"/>
Date of birth <input type="text"/>	Date of detention <input type="text"/>
Ethnicity <input type="text"/>	Current placement <input type="text"/>
Religion <input type="text"/>	Date of admission to current placement <input type="text"/>
First language <input type="text"/>	Current placement contact name <input type="text"/>
Personal telephone number <input type="text"/>	Current placement telephone <input type="text"/>
Personal email address <input type="text"/>	Does the patient have an EHCP? <input type="text"/>
Patient home address <input type="text"/>	
Specific communication considerations <input type="text"/>	

**Important contact details**

Guardian/nearest relative name		
Telephone		Email
Current responsible clinician name		
Telephone		Email
GP name and clinic		
Telephone		Email
Care coordinator name		
Telephone		Email
Social worker name		
Telephone		Email
Bed manager name		
Telephone		Email

**Referrer details**

Referrer name		Telephone	
Organisation		Email	

**Authorisation/commissioning details**

Organisation responsible for funding		
Telephone		Email
<p>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 and that signature of this referral form is taken as acceptance of St Andrew's Healthcare Terms of Business. The current version of these terms are available at <a href="http://www.stah.org/making-a-referral">www.stah.org/making-a-referral</a> or on request.</p>		
Name		Digital signature
Telephone		Patient's unique reference

**Please note:**

- For all admissions, we require a signed Named Patient Agreement, which will be sent post admission via the admissions team.
- Unless and until an alternative fee arrangement has been agreed and confirmed in writing by us, please be aware our fees will be based on our 'acute fees', which are available upon request. These will continue to be reviewed during the patient's placement.
- 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.
- Our fees for PICU and acute patients do not include transport to or from the referring authority.

**Reason for referral**

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

6 lines

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

- MHA section papers
- 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
- If currently an inpatient, last 24 hours' progress notes

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

- |  |  |
|--|--|
| <input type="checkbox"/> Psychiatric report  | <input type="checkbox"/> Discharge summaries                       |
| <input type="checkbox"/> Patient risk assessment including risk/incident logs        | <input type="checkbox"/> List of current medications including PRN |
| <input type="checkbox"/> Manager's hearing report - psychiatric and social work      | <input type="checkbox"/> Current care plan                         |
| <input type="checkbox"/> Mental health tribunal report - psychiatric and social work | <input type="checkbox"/> Forensic summary                          |
| <input type="checkbox"/> Gatekeeping assessment                                      | <input type="checkbox"/> 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](http://www.stah.org/making-a-referral)

To view our privacy policies visit [www.stah.org/privacy](http://www.stah.org/privacy)