

Patient Name:



 Date of Referral:

Psychiatric Intensive Care (PICU) inpatient referral form

Before completing this form, please phone or email the relevant ward you would like to refer to.

When advised to do so, please complete this form, Save as, and then send as an email attachment with accompanying information directly to the relevant ward.

PICU Contact Details

| | | | |
|---|---------------------------|--------------------------|--|
| Female PICU  | Frinton Ward, Essex | Telephone: 01268 723 860 | Email: SAH.PICUFemaleEssex@nhs.net |
| | Bayley Ward, Northampton | Telephone: 01604 614 584 | Email: SAH.PICUFemaleNorthampton@nhs.net |
| Male PICU  | Audley Ward, Essex | Telephone: 01268 723 930 | Email: SAH.PICUMaleEssex@nhs.net |
| | Heygate Ward, Northampton | Telephone: 01604 616 111 | Email: SAH.PICUMaleNorthampton@nhs.net |

Patient Details

| | |
|-------------------------------------|---|
| Name <input type="text"/> | Patient diagnosis <input type="text"/> |
| NHS Number <input type="text"/> | Current placement <input type="text"/> |
| Gender <input type="text"/> | Date of admission to current placement <input type="text"/> |
| Date of birth <input type="text"/> | Current placement contact name <input type="text"/> |
| First language <input type="text"/> | Current placement telephone <input type="text"/> |
| Religion <input type="text"/> | Legal status <input type="text"/> |
| Ethnicity <input type="text"/> | Date of detention <input type="text"/> |

Important Contact Details

| | |
|---|--------------------------------|
| Guardian/Nearest Relative name <input type="text"/> | Telephone <input type="text"/> |
| Current Responsible Clinician name <input type="text"/> | Telephone <input type="text"/> |
| GP name + clinic <input type="text"/> | Telephone <input type="text"/> |
| Care Coordinator name <input type="text"/> | Telephone <input type="text"/> |
| Social Worker name <input type="text"/> | Telephone <input type="text"/> |
| Bed Manager name <input type="text"/> | Telephone <input type="text"/> |

Referrer Details

| | |
|------------------------------------|--------------------------------|
| Referrer name <input type="text"/> | Telephone <input type="text"/> |
| Organisation <input type="text"/> | Email <input type="text"/> |

Patient Name:

 Date of Referral:
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 post admission via the 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 | • Current medication and care provided |
| • Psychiatric history | • Social history, incl. current significant relationships |
| • Medical history (incl. allergies and drug reactions) | • Risk history |
| • Drug and alcohol 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.

- | | |
|--|--|
| <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 the relevant PICU ward who will contact you shortly.

Patient Name:

Date of Referral:

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

Charges:

1. Unless and until an alternative fee arrangement has been agreed and confirmed in writing by us, our fees will be based on the schedule of charges featured below effective from 1st April 2021. St Andrew's Healthcare reviews its charges annually; you will be notified of any rate change at the appropriate time.
2. Enhanced Support will incur an additional charge.
3. Periods of leave where the bed is kept reserved for the patient, will be charged at 100% of the daily charge for the first 5 days and then at 85% of the daily charge thereafter.
4. The first invoice will be issued within 14 days of the admission and thereafter invoices are raised in advance on the second working day of each month. Invoices will be sent directly to the designated invoice address, with payment due within 14 days of the invoice date.
5. Transport - Our daily rate for PICU patients does not include transport to or from the referring authority.

Daily charges are generally all inclusive with the following exceptions which will be charged as and when used:

- Tests and procedures that have to be acquired from other health care providers
- Exceptional drug costs not related to mental health status
- Enhanced Support
- Staff and travel costs associated with court/home/hospital visits/patient discharge
- Translator costs

When completed and saved as, please send as an attachment with accompanying information directly to the relevant ward.

Save