

Patient Name:

 Date of Referral:

Neuropsychiatry Rapid Response inpatient referral form

Before completing this form, please contact the admissions team or outside of office hours please contact Aspen ward in our Lowther Dementia Hub stating you would like to make a Rapid Response referral.

When advised to do so, please complete this form, Save as, and then send as an email attachment to:

8:30am - 5:30pm - SAH.admissions@nhs.net

Out of hours - contact ward for email details

Rapid Response Contact Details

Admissions team Telephone: 0800 434 6690 Email: SAH.admissions@nhs.net

Aspen - Lowther Dementia Hub Telephone: 01604 616000 Email: contact ward for details

Please contact Admissions Team Monday-Friday 8:30am - 5:30pm or Lowther Dementia Hub outside of office hours.

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

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:
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 | • 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 our admissions team or, if out of hours, contact Aspen ward for email details.

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

St Andrew's is a no smoking environment

Save