**Assessment will only be considered on competition of this form and receipt of relevant clinical documents.**

**CUSTOMER INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Email Address:** |  |
| **Job Title:** |  | **Telephone:** |  |
| **Date of Referral:** |  | **CCG:** |  |
| **Time of Referral:** |  | **Funder’s Name:** |  |

**ABOUT THE SERVICE USER**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Responsible Clinician:** |  |
| **Date of Birth:** |  | **RC’s Email:** |  |
| **Gender:** |  | **RC’s Telephone:** |  |
| **Next of Kin:** |  | **Current Placement:** |  |
| **Legal Status:** |  | **Telephone No:** |  |
| **NHS Number:** |  | **Diagnosis:** |  |
| **Current GP:** |  | **IQ (If applicable):**  |  |
| Is the individual detained under the Mental Health Act? **If yes, please supply section info:****Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   |

**Reason for Referral:**

|  |
| --- |
|  |

**Summary of Current Presentation:**

|  |
| --- |
|  |

**Past Psychiatric / Social History Including Previous Admissions:**

|  |
| --- |
|  |

**Physical Health History & Current Physical Health Issues:**

|  |
| --- |
|  |

**COVID-19 Status / Vaccination Status:**

|  |
| --- |
|  |

**Current Medication & Use of PRN:**

|  |
| --- |
|  |

|  |  |  |
| --- | --- | --- |
| **Risks:**please complete or attach most recent risk assessment | **Current risk:** (Please delete as appropriate) | **Historical risk:** (Please delete as appropriate) |
| **Suicide** | Yes/No | Yes/No |
| **Deliberate self-harm** | Yes/No | Yes/No |
| **Self-neglect** | Yes/No | Yes/No |
| **Non-adherence with treatment** | Yes/No | Yes/No |
| **Violent, aggressive, intimidating behaviour** | Yes/No | **Date of most recent incident** |
| **Absconsion / escape** | Yes/No | Yes/No |
| **Inappropriate sexual behaviour** | Yes/No | Yes/No |
| **Using or supplying drugs or alcohol** | Yes/No | Yes/No |
| **Arson** | Yes/No | **Date of most recent incident** |
| **Accidental fire setting** | Yes/No | **Date of most recent incident** |
| **Risk to staff** | Yes/No | Yes/No |
| **Risk of harmful substance withdrawal** | Yes/No | Yes/No |
| **Physical health** | Yes/No | Yes/No |
| **Internet and social media** | Yes/No | Yes/No |
| **Other risk factors (please detail)** | Yes/No | Yes/No |
| **List of recent incidents – last three months** | Yes/No | Yes/No |
| **Any safeguarding concerns (Please state the body they have been raised with)** | Yes/No | Yes/No |
| **Any other comments:** |  |
| **Any Other Risks Identified:** |  |

**In addition to the Referral Form, we would also require the following information:**

* **MHA Paperwork**
* **7+ days Daily Notes**
* **Current Medication Card**
* **Care Plans / MDT Reports**
* **Social Worker Reports**

**This referral form needs to be filled in and agreed by a healthcare professional only.**

**We can support referrals Monday to Friday between the hours of 8:30am and 5pm. Our services work towards a two-hour turnaround time for all referrals needing an acute admission.**

**Email:** **acutereferrals@bramleyhealth.co.uk** **NHS Email:** **acutereferrals.bramley@nhs.net**

 **Landline: 01424 819 829 Mobile: 07467 481 884**