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| **Referral to Adult Mental Health Services****\*All text areas expand to enable you to give as much detail as possible in your referral. If insufficient information is given you may be contacted to provide the required information before the referral can be processed\*** |
| **Patient Details** | **Referrer/ GP details (if you are not the GP please give contact details and telephone number).** |
| **NHS no:** <NHS number>  **D.O.B.** <Date of birth> | **GP Practice** <Sender details> |
| **Sex** <Gender> | **GP Name**  |
| **Title :** <Patient name>**Name:** <Patient name> | <Sender name> |
| **Address** <Patient address> | **Address** <Sender address> |
| **Postcode** <Patient address> | **Postcode** <Sender address> |
| **Landline** <Patient contact details> | **Telephone** <Sender details> |
| **Mobile** <Patient contact details> | **Fax** <Sender details> |
| **Date of referral** <Todays date> |
| **Access needs (e.g. wheelchair user, requires transport). Specify details**<Diagnoses> |
| **Interpreter required** | **Yes** **[ ]**  | **No****[ ]**  | **Language** | <Main spoken language> |
| **Ethnicity :** <Ethnicity> |  |
| **Patient aware of the referral** | **Yes** **[ ]**  | **No** **[ ]**  |
| **Does the Patient consent to share their electronic record?** | **Yes** **[ ]**  | **No** **[ ]**  |
| **Reason for referral (Please indicate severity and impact on patients ability to carry out activities of daily living).**       |
| **Date of onset of current problem**  |       |
| **Previous use of Mental Health Services please include details of CMHT, Therapy and inpatient services**       |
| **Social circumstances /housing/ finances**       |
| **Are any other professionals involved?** **Please provide names and contact details**       |
| **Next of Kin/ Carer details**      |
| **Risk to self and others (where risk is present please provide full details of type of risk posed and to whom)**       |
| **Safeguarding children issues (if there are risks ensure full names and dates of birth of all children are detailed here with specific risks highlighted).**      |
| **Safeguarding adult issues: Is the person a vulnerable adult Yes** **[ ]  No** **[ ]** **Is the person experiencing domestic violence Yes** **[ ]  No** **[ ]** **If you have answered yes to either of the above please detail relevant information below and ensure that you have referred as necessary.** |
| **Is the patient pregnant** | **Yes** **[ ]**  | **No** **[ ]**  |
| **If YES – What is the EDD** |  |
| **Does the patient have a child under the age of 1** | **Yes [ ]**  | **No [ ]**  |
| **If YES, provide DOB of child** | **Yes [ ]**  | **No [ ]**  |
| **Is the patient a Veteran?** | **Yes** **[ ]**  | **No** **[ ]**  |
| **Latest PHQ 9 score** |  | **Date**  | **Latest GAD 7 score** |       | **Date**       |
| **Employment status****Please tick appropriate status** |
| **Full time** **[ ] employment** | **Home maker** **[ ]**  | **Part Time** **[ ]** **employment**  | **Unemployed** **[ ]**  |
| **Student** **[ ]**  | **Retired** **[ ]**  | **Carer** **[ ]**  | **In receipt of benefits** **[ ]**  |
| **Medication list** **Current Acute Issues**<Medication>**Current Repeat Templates**<Repeat templates> |
| **Allergies** | <Allergies & Sensitivities> |
| **Past Medical History** **Summary**<Summary>**Problems**<Problems> |
| **Family History**  | <Family history> |
| **Latest Biometric Values** **Latest Weight**: <Latest Weight> **Latest Height**: <Latest Height>**Latest BMI:** <Latest BMI> **Latest BP:** <Latest BP> |
| **BRADFORD & AIREDALE single point of access for NON urgent referrals** | **ELECTRONICALLY THROUGH SYSTM ONE** **Fax: 01274 215411 (This should be used for any letters** **and correspondence that aren’t accessible through** **SYSTM ONE)** |
| **BRADFORD & AIREDALE single point of access for URGENT referrals** | **Tel: 01274 221181** |