Professionals Referral Form to Community Mental Health Services:

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| --- | --- | --- | --- | --- | --- | --- |
| **Mr/Mrs/Ms/Miss** |  | | | | **Date of Birth** |  |
| **Surname** |  | | | | **Forename** |  |
| **Address** |  | | | | **Male/Female** |  |
| **NHS. Number** |  |
| **Post Code** |  | | | | **Ethnicity** |  |
| **Home Telephone** |  | | | | **Marital Status** |  |
| **Next of Kin** |  | | | |  |  |
| **Mobile Telephone** |  | | | | **Preferred Contact**  **Number** |  |
| **Has this person consented to this referral? YES/NO** | | | | | | |
| **GP Name** | |  | **Address & Telephone Number** | | |  |
|  | |  | |  | |  |
| **Referral Source** | |  | | **Referral Urgency** | | * Emergency – same day assessment * Urgent – within 5 working days * Routine – within 20 working days   Please note your referral will be triaged and referral urgency may be changed following triage assessment. |
| **Referring professional and contact details.** | |  | | **GP Patient Profile Requested** 🞏  (CFT admin) | | |
| **Reason for Referral** | | **Primary Reason for Referral**   |  | | --- | | * Suspected 1st episode of psychosis * On-going or recurrent psychotic symptoms * Depression * Bi Polar Affective Disorder * Anxiety * Obsessive compulsive disorder * Phobia * Drug & alcohol difficulties in relationship with mental illness * Unexplained medical symptoms * Post-traumatic stress disorder * Eating disorder * Perinatal mental health * Personality disorders * Self-harm behaviours * In crisis * Requires diagnosis * Medication queries | |  | |  | |  | |  | | | | | |
|  | | CONCERNS ABOUT RISK: (self, others, children) | | | | |
|  | | Presenting situation:  Current treatment provided:  Previous treatment provided:  Other relevant details. | | | | |