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** |  |
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| **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**

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| * 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
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|  | CONCERNS ABOUT RISK: (self, others, children) |
|  | Presenting situation:Current treatment provided:Previous treatment provided:Other relevant details.  |