**Patient referrals must be completed with ALL required information. In line with CCG requirements, incomplete referrals will be rejected and returned to the referrer for review or clarification. This may cause a delay in management.**

**On completion of the form please send to :** [ckspareferrals@swyt.nhs.uk](mailto:ckspareferrals@swyt.nhs.uk)

**For urgent referrals please ring spa on :- 01924 316830**

|  |  |  |
| --- | --- | --- |
| Referrer Details | | |
| Referrer Name : <Your name>  Referrer Position : <Your Details> | | Telephone :<Organisation Details>  Email: <Organisation Details> |
| **Patient Details**  Please check all details are correct and up to date | | |
| **Title**: <Patient Name>  **First Name:** <Patient Name> **Known As:** <Patient Name>  **Surname:** <Patient Name>  **Home Address:** <Patient Address>  **Home Tel:** <Patient Contact Details>  **Mobile:** <Patient Contact Details>  **Current Address if different from above:**        (Could we use the Temporary Address Field for this?) | **Date of Referral:** <Today's date>  **NHS number:** <NHS number>  **Gender:** <Gender>  **Ethnicity:** <Ethnicity>  **Date of Birth:** <Date of Birth>  **Age:** <Patient Age>  **Are they carer?:**  Yes  **Do they have a carer:**  Yes  **Consent to Share**  Has the patient consented to share out their care record?  **Consented to Share**  **Declined** | |

|  |  |  |
| --- | --- | --- |
| **Communications / Other Considerations** | | |
| **Language:** <Main spoken language>  **Interpreter required?**  Yes  No | | **CONTACTING THE PATIENT**  Is the patient aware of and consenting to the Referral  Yes  Does the patient consent to secondary care services contacting them on their mobile or sending a text?  **Yes**  **No**  If no, please specify alternative contact preferred   |
| **Special Needs to Consider (tick all that apply)** | |
| Vision impairment  Physical disability  Mobility | Hearing impairment  Learning disability |
| Other – please specify  | |

|  |
| --- |
| **Children Details** |
| **Children**: Please give details of all children under 18 known to have regular contact with the patient (if possible please include name, DoB, address if different to patient, GP details    **Is there a young carer in the family?**   **Y** |

|  |  |
| --- | --- |
| **Next of Kin Details** | **GP Details** |
| **Name:** <Relationships>  **Address:** <Relationships>  **Contact Details:** <Relationships>  **Relationship to patient:**  | **Registered GP:** <GP Name>  **Practice:** <Sender Details>  **Address:** <Sender Address>  **Tel:** <Sender Details> |

|  |  |
| --- | --- |
| **Appointment Urgency** (Assessed using triage scale in Calderdale) | **Service Requested (if known)** |
| **Advice and Guidance Only**  **Routine (within 14 days)**  **For urgent referrals please ring spa on :-**  **01924 316830** | Adult CMHT (inc. psychiatrist opinion)  Early Intervention Psychosis  Older Adult CMHT  Memory Services  Care Home Liaison |

|  |  |  |
| --- | --- | --- |
| **Referral Details** | | |
| **Reason for Referral** Include nature, duration and severity of formal mental health problems and current circumstances e.g. behaviour, mood, psychotic symptoms, and any suggested or requested inputs.    <Event Details>  **Social and Personal Circumstances** Give details of lifestyle / occupation / social circumstances including any accommodation issues especially any significant current life stresses      **Risk Assessment** Based on the information you have available, are there any current or historical risks (tick Yes or No) and give details : | | |
| Suicidality…………………...  Self-harming behaviour.......  Risk to others……………....  Current Substance Misuse.. Safeguarding concerns……  Evidence of Self-neglect….. | Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No |          |
| Other risks /issues that might impact assessment e.g. gender of assessor or requiring 2 clinicians  Yes  No   Significant others concerns  | | |
| ***Legal Information*** *Insert any legal considerations e.g. Deprivation of Liberty, Mental Capacity, Lasting Power of Attorney, Safeguarding, Advance Decisions*  *Primary Care to add DoLS Applications and MCA merge fields. Configured lists currently not set up in MH Unit SystmOne Also include free text box*  ** | | |

**Additional Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Clinical Details** | | | |
| **Marker** | **Last Value** | **Marker** | **Last Value** |
| **BP:** | <Latest BP>, <Numerics> | **Pulse:** | <Numerics>, <Diagnoses> |
| **Hba1c:** | <Numerics> | **Cholesterol:** | <Numerics> |
| **Smoking Status:** | <Diagnoses>, <Numerics> | **Frailty:** | *Primary Care to check for read codes – moderate and severe frailty* |
| **BMI:** | <Numerics>, <Latest BMI> |  |  |
| **Alcohol:** | <Diagnoses>, <Numerics> | | |

***Any Other Information***

|  |
| --- |
| **Medical History** |
| **Past Medical History** Insert past history, including dates of any investigations or interventions especially past history of mental health treatment and any information regarding engagement.    <Problems>  **Active Problems** Insert any ongoing health issues. Is the patient currently receiving other medical care, investigations or treatment?    <Summary>  **Current Acute Medication**  <Medication(table)>  **Current Repeat Medication**  <Medication(table)>  **Allergies and Sensitivities**  <Allergies & Sensitivities(table)> |

|  |  |  |
| --- | --- | --- |
| **Memory Service Referrals**  For memory services referrals, the following fields must be completed. **PLEASE ENSURE ALL INVESTIGATIONS HAVE BEEN DONE**. Failure to do so may result in the referral being returned. | | |
| **MMSE/AMT:** | <Scored Assessment(table)> |  |
| **6CIT:** | <Scored Assessment(table)> |  |
| **Bloods:** | Hb <Numerics>, WCC <Numerics>, Plts <Numerics>, MCV <Numerics>, Neut <Numerics> |  |
| **U&E** | Na <Numerics>, K <Numerics>, Urea <Numerics>, Creat <Numerics>, eGFR <Numerics> |  |
| **ECG:** |  |  |
|  | |  |
| **Other physical Investigations e.g. MRI, CT:** | |  |