Patient Referral Form

Alpha Hospital Woking
A STATE OF MIND

PLEASE COMPLETE ALL SECTIONS AND RETURN BY FAX ON 01483 795150. FOR FURTHER INFORMATION PLEASE CONTACT THE ADMISSIONS COORDINATOR ON 01483 795 100

REFERRERS DETAILS	
NAME: DESIGNATION:	ORGANISATION:
ADDRESS: POSTCODE: TELEPHONE NO: EMAIL ADDRESS:	 FAX NO:
FUNDING – PLEASE ENSURE THAT YOU HAVE INFORMED THE FUNDING AUTHORITY OF THIS REFERRAL	
NAME OF PCT/TRUST:	CONTACT PERSON:
ADDRESS: POSTCODE: TELEPHONE NO: EMAIL ADDRESS:	 FAX NO:
PATIENT DETAILS	
FULL NAME:	DOB: GENDER:
HOME ADDRESS: POSTCODE: HOME TELEPHONE NO:	 MOBILE:
ETHNICITY: *see note on page 4.* NATIONALITY:	FIRST LANGUAGE: TRANSLATOR REQUIRED: YES/NO
NEXT OF KIN: ADDRESS: TELEPHONE NO.	
LOOKED AFTER CHILD: YES/NO SUBJECT TO COURT ORDER: YES/NO If YES please give details	
GP NAME: ADDRESS: TELEPHONE NO.	NHS NUMBER: FAX:

LEGAL STATUS – *IT IS ESSENTIAL THAT WE RECEIVE ALL SECTION PAPERS WITH THE SUPPORTING DOCUMENTS IN ADVANCE OF ADMISSION, INCLUDING THE AMHP ASSESMENT REPORT IF THE PATIENT IS DETAINED UNDER 2 OR 3 OF THE MHA.*	
SECTION:	DATE DETAINED:
CPA LEVEL:	

REASON FOR REFERRAL			
SERVICES OFFERED AT ALPHA HOSPITAL WOKING		SECURE BED REQUIRED	
RECOMMENDATION		EMERGENCY BED REQUIRED	
NO LOCAL NHS FACILITY AVAILABLE		LOCATION	
LOCAL NHS FACILITY IS FULL		BED RATE	
OTHER, please state			

AIMS OF REFERRAL – LONG TERM AND SHORT TERM AIMS

EVENTS LEADING TO REFERRAL

PSYCHIATRIC HISTORY

FORENSIC HISTORY

CURRENT MEDICATION – PHYSICAL AND PSYCHIATRIC

PHYSICAL HEALTH – DOES THE PATIENT HAVE ANY PHYSICAL HEALTH PROBLEMS (TICK AS APPROPRIATE)			
YES		NO	
IF YES PLEASE GIVE DETAILS			

OTHER INFORMATION

PLEASE ATTACH ANY SUPPORTING REFERRAL DOCUMENTATION

RISK ASSESSMENT

RISK OF HARM:		Yes	No
PATIENT TO OTHERS	PERSON		
	PROPERTY		
PATIENT TO SELF	PERSON		
	PROPERTY		
OTHERS TO PATIENTS	PERSON		
	PROPERTY		
RISK OF ABSCONDING			

RECENT RISK BEHAVIOUR

REFERRER'S SIGNATURE:

DATE:

Ethnic Classifications

White

A. British
B. Irish
C. Any other White background

Mixed

D. White and Black Caribbean
E. White and Black African
F. White and Asian
G. Any other mixed background

Asian or Asian British

H. Indian
J. Pakistani
K. Bangladeshi
L. Any other Asian background

Black or Black British

M. Caribbean
N. African
P. Any other Black Background

Other ethnic Groups

R. Chinese
S. Any other ethnic group
Z. Not Stated

IMPORTANT CONTACTS SHEET

PLEASE LIST ANY CONTACTS THAT YOU FEEL SHOULD BE KEPT INFORMED OF THIS PATIENT'S CASE AND INVITED TO MEETINGS SUCH AS CPAs. PLEASE NOTE IT IS OUR AIM TO HOLD THE CPA MEETING ON THE THIRD TUESDAY AFTER ADMISSION. CONFIRMATION OF EXACT TIME AND DATE WILL BE PROVIDED FROM OUR CPA CO-ORDINATOR.

Primary community contact or care coordinator	***Social work contact***
Name: Job Title: Organisation: Address: Telephone Number: Fax: Email Address:	Name: Job Title: Organisation: Address: Telephone Number: Fax: Email Address:
Nearest relative (under the MHA) if different from next of kin	***Community psychiatrist***
Name: Job Title: Organisation: Address: Telephone Number: Fax: Email Address:	Name: Job Title: Organisation: Address: Telephone Number: Fax: Email Address:
School/ Education	***Other***
Name: Job Title: Organisation: Address: Telephone Number: Fax: Email Address:	Name: Job Title/Relationship to Patient: Organisation: Address: Telephone Number: Fax: Email Address:
Other	***Other***
Name: Job Title/Relationship to Patient: Organisation: Address: Telephone Number: Fax: Email Address:	Name: Job Title/Relationship to Patient: Organisation: Address: Telephone Number: Fax: Email Address: