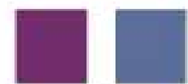

LUDLOW STREET HEALTHCARE GROUP

REFERRAL FORM

NAME:

UNIT:

COMPLETED BY:

DATE:

Please complete all sections in relevant detail, where necessary please continue on separate sheet attached

1. Personal Details

Surname: **First Names:**

National Insurance number:

Current Diagnosis:

Cognitive Functioning / IQ:

Medication:

Present Address:

Post Code: **Telephone Number**

Age	Date of birth	Gender	Ethnic Origin	Religion

2. Referring Agency

Referrer Name:

Designation:

Address:

Telephone Number:

E-mail address:

Involved Professional / Agencies:

Psychiatrist	Yes	No
Primary Nurse	Yes	No
CPN	Yes	No
Occupational Therapy	Yes	No
Activity Co-ordinator	Yes	No
Social Worker	Yes	No
Probation Officer	Yes	No
Other (please specify)	Yes	No

Name of person holding financial authority:

Designation:

Address

Telephone Number

Has funding been agreed? Yes No In principle

3.Service.	**3(a) Type of Placement Required**
Forensic Learning Disabilities / Challenging Beh. Autism Specialist Asperger Elderly Forensic / Elderly challenging Beh. Huntington's Disease Assessment and treatment services Early Dementia	Medium Low Open unit Specialist Group Home

TO HELP US PROCESS THIS REFERRAL SPEEDILY, PLEASE ATTACH COPIES OF MOST RECENT AND RELEVANT ASSESSMENTS OR REPORTS

4. Mental Health Act Information

Is your Client currently detained under the Mental Health Act ? Yes No

Please specify which section of the act

Please state the **date the section commenced** and the forthcoming **expiry Date**

Please specify form of Mental disorder(s) the patient has been classified. (under the Mental Health Act)

Has your client had a tribunal or is there a Tribunal Pending? If so please give dates and decisions reached.

Please give the name of the Mental Health Coordinator / Medical Records Officer from whom the section papers will be requested from, prior to admission of the patient to any of our services.

Name: **Telephone Number:**

5. Family Contacts:

Next of kin / significant family member

Name: **Relationship:**

Address:

Telephone Numbers:

Home: **Work:**

Mobile:

Name: **Relationship:**

Address:

Telephone Numbers:

Home: **Work:**

Mobile:

6. Reason For Referral

Please Summarise in sections 7-15 in space provided and attach relevant reports

7. Social and family History

8. Educational And Occupational History

9. Psychiatric History

10. Offending History

Summary

11. Adaptive Functioning

Self care, independent life skills etc.

12. Medical Information

13. Dietetics

14. Mobility

15. Behavioural Difficulties

Verbal Aggression

Physical aggression

Destruction of the environment

Use of weapons

Substance abuse

Fire setting

Absconding

Vulnerability

Inappropriate sexual behaviour

Self Harm

Relationship Issues:

Please attach any relevant reports, eg., clinical psychology etc.

16. RISK ASSESSMENTS (please attach current risk assessments if available)

Current staffing ratios

In house:

In community:

Unescorted Leave:

17. Other information

18. Person Completing form:

Name:
Designation:
Date:
Address:
Contact Numbers:
E. Mail: