



Web Referral Form

Referrer Details			
Name of referrer:			
Telephone number:		Fax number:	
Status of referrer:		Trust or Hospital:	
Authority responsible for funding:			
Patient Details			
Name of patient:		Date of birth:	
Ethnicity:		Gender:	
Nearest relative:		Telephone number:	
Status MHA (1983):		Date implemented:	
Expiry date:		GP:	
Details of Referral			
Type of Referral: Please circle one	Emergency	Urgent	Planned
Immediate Problems and Risks Presented: Please circle if relevant	Abscnson	Aggression	Alcohol abuse
	Arson	Depression	Drug abuse
	Non-compliance	Self harm	Sexually Disinhibited
	Suicidal	Unpredictable	
	Other (please specify)		
Type Of Service Required: Please circle if known	Acute Psychiatric Care	Adolescents	Addictions/Alcohol Detox
	Asperger's Syndrome/ High Functioning Autism	Borderline Personality Disorder/Self Harm	Community Rehabilitation
	Eating Disorders	Low Secure Complex Needs	Low Secure Rehabilitation
	Medium Secure Services	Psychiatric Intensive Care Units	Prison Transfer Service
Additional Information: Please provide further information on the following and where necessary fax all relevant documentation along with this referral form:			
<ul style="list-style-type: none"> • problems and risks which have been identified • details of where the patient is currently placed • details of events leading up to the referral and why admission is required 			
Please tick to confirm you have faxed relevant documentation with this referral form:			
Date of Referral:		Time of Referral:	
Signature of Referrer:			