

Patients Referral Form

Women's Service



CYGNET FEMALE HOSPITAL

**Please complete ALL sections and return form to
Cygnets Health Care fax: 020 7511 3399**

REFERRER'S DETAILS	
Date: (dd/mm/yy)	Contact Address:
Name of Referrer:	
Name of Organisation:	Postcode:
Contact Phone No:	Email Address:

PATIENT'S DETAILS		
Full Name: (please print)		
Date of Birth (dd/mm/yy)	Current Age:	
Marital Status:	Ethnic Group:	Patients 1 st Language:
Patients Last Known Home Address:		
Postcode:		
NHS Number: (Compulsory)	Social Service Identification Number:	
Year of First Mental Health Treatment:		
Last Know GP's Name:	GP's Address:	
GP's Contact Phone No:	Postcode:	

DETAILS OF PATIENT'S CURRENT PLACEMENT	
Organisation Name:	Organisation Address:
Contact Name:	
Phone Number:	Postcode:

CYGNET FEMALE HOSPITAL

FUNDING – (Who will fund the placement at Cygnet Female Hospital)	
PCT / Trust Name:	
Contact Name:	Contact Phone Number:
Contact Address:	
Postcode:	
<i>Please ensure that you have informed the PCT / Trust of this Referral</i>	

LEGAL STATUS		
Informal: Yes / No	Section:	Mental Category:

PLEASE LIST BELOW ANY PROFESSIONALS INVOLVED IN THE PATIENT'S CARE <small>i.e., Clinical Lead, Social Worker</small>			
<u>Name</u>	<u>Designation</u>	<u>Address</u>	<u>Contact Phone Number</u>

SUMMARY OF DIAGNOSIS / MAIN PROBLEMS			
Please tick:			
Learning Disability: Mild / Moderate (please indicate)		Mental Illness	
PICU	Rehabilitation & Complex Needs	Personality Disorder	
Please give details:			
PLEASE ATTACH ANY SUPPORTING REFERRAL DOCUMENTATION i.e., Psychiatric Reports, Risk Assessment reports, Mental Health Tribunal reports			

IS THERE ANY OTHER RELEVANT INFORMATION e.g., chronic physical illness/handicaps?

PLEASE ADVISE IF THE PATIENT HAS BEEN REFERRED TO ANY OTHER ORGANISATION
Name of Organisation:
1.
2.
3.

REASON FOR REFERRAL (please tick relevant boxes below)			
No Local NHS facility available		Secure bed required	
Local NHS facility is full		Cost of bed	
Specialist service offered at Cygnet Female Hospital		Location	
Cygnet's reputation / Recommended		Emergency bed required	
If there is any other reason for the referral please state;			

**This information will be held securely under the Data Protection Act. The information will not be released without further consent from the originating organisation. Your details will be held in a database and maybe used for marketing purposes by Cygnet Healthcare. If you object to us sending you detail of our services, please tick here:

CYGNET FEMALE HOSPITAL

Next of Kin:	
Address:	
Nearest Relative: (For purpose of Mental Health Act)	
Address:	
Main Contact Person (If different from next of kin)	
Address:	

CPA Reviews	
Date of Last CPA Review:	
Date of Next CPA Review:	

Patient's View of Referral:

Family/Carer's View of Referral:

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Medical History:

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Developmental and Personal Details:

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Family Details:

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Educational and Occupation Details:

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Psychosexual Details:

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Forensic History: (if not covered in risk details)(please attach any criminal records etc)

Alcohol and Illicit Substance Use:

Current Mental State:

Current Medication:

Current Interventions e.g. psychologist, OT, nursing

Any comments that you have regarding this form, in particular its ease of completion would be appreciated.
Please make your comments on the back of page 6

Thank you for completing this referral form.