

CYGNET CLINIC - BECKTON
MALE LOW SECURE SERVICES

Cob Rehab Referral Form

Fax to: 020 7511 3399

Referrers Name:	Telephone:	
Status of Referrer:	Trust or Hospital:	
Patients Name:	DOB:	Ethnic Origin:
Address:	Status (MHA 1983):	Date Implemented:
	Expiry Date:	
Nearest Relative:	Contact Telephone No:	
Authority Responsible for funding:	Funding Authorised by:	
GP Details:	Name:	
	Tel No:	

DATE OF REFERRAL:	Time:
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<u>Type of referral</u>		
EMERGENCY	URGENT	PLANNED

REASON FOR REFERRAL		
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IMMEDIATE PROBLEM AND RISKS PRESENTED: (Please Tick)			
	Yes		No
SUICIDAL			
SELF HARM			
VIOLENCE & AGGRESSION			
ABSCONSION			
FIRE STARTER			
NON-COMPLIANCE			
DRUG ABUSE			
ALCOHOL ABUSE			
UNPREDICTABLE			

Severity of Problems: (please give examples of the identified risks / problems and events leading up to current referral and reason(s) why Low Secure Rehabilitation admission is required)
