

**NEW DAWN
SPECIALIST WOMEN'S SERVICE**

Telephone No: 0207 511 2299

Fax: No.: 0207 476 8270

REFERRAL FORM

REFERRER NAME:/STATUS:		TEL NO.:	DATE REFERRED:
		FAX NO.:	
PATIENTS DETAILS			
NAME:	DOB:	ETHNIC ORIGIN:	RELIGION:
ADDRESS:	HOSPITAL HOSPITAL CURRENTLY ADMITTED:		TRUST:
NHS CONSULTANT:	TEL NO.:	KEYWORD/KEYWORD:	TEL NO.:
NAME OF WARD/CMHT SECTOR:	SOCIAL W SOCIAL WORKER/ CPN	TEL NO.:	
DATE OF ADMISION:	MHA STATUS:		
REASON FOR REFERRAL/AIMS OF REFERRAL:			
HISTORY OF CURRENT ADMISION:			
PAST PSYCHIATRIC HISTORY			
(Including diagnosis & previous treatments)			
PREVIOUS SECTION:			
PREVIOUS FORENSIC/SECURE SETTINGS:			
PREVIOUS PSYCHOTHERAPY:			
WHAT HAS WORKED?			
PAST MEDICAL HISTORY			
ANY KNOWN MEDICAL PROBLEMS/DISABILITIES			
YES NO			
IF YES PLEASE GIVE DETAILS			
CURRENT MEDICATION:			
PRN USED IN THE LAST WEEK			
LAST 1/12 HIGHEST PRN IN 1/7			
FAMILY & PERSONAL HISTORY			
DRUG & ALCOHOL			
IS DETOX REQUIRED?		YES	NO
IS MAINTENANCE REQUIRED		YES	NO
FORENSIC HISTORY			
PREVIOUS OFFENCES:			
OUTSTANDING AND CURRENT COURT PROCEEDINGS:			
RISKS:			
SUICIDE			
DELIBERATE SELF HARM			
AGGRESSION (including use of weapons)			
ARSON:			
ABSCONSION			
SELF NEGLECT			
MENTAL STATE			
CURRENT MANAGEMENT:			
NUMBER OF RESTRAINTS IN THE LAST WEEK:			
ANY CURRENT NURSING DIFFICULTIES:			
CURRENT NURSING OBSERVATION LEVEL:			
ANY SPECIAL REQUIREMENTS:			
Please fax the following:			
1. Current prescription chart			
2. Last weeks inpatient notes			
3. Discharge summaries			
4. Tribunal reports			
5. Current CPA			
6. Risk Assessment			
Witholding relevant information prior to transfer could jeopardise admission and the patient may be returned with immediate effect.			

For office use only:		
ADMISSION RECEIVED BY:		
NAME:.....	SIGNATURE:	DATE:.....
NAME OF OTHERS INVOLVED:	1	
	2	
	3	