

CYGNET HOSPITAL WYKE REFERRAL FORM

AUSTEN WARD (male only) fax to 01274 604600
BRONTE WARD (female only) fax to 01274 601300
SHELLEY WARD (male only) fax to 01274 600199

DATE: _____ TIME: _____

Name of referrer:	TEL:
	FAX:
Status of referrer:	TEL:
	FAX:
Hospital/Trust	TEL:
	FAX:
Health Authority:	TEL:
	FAX:
NHS Consultant if not referrer:	TEL:
	FAX:
Social Worker:	TEL:
	FAX:
CPN/Keyworker	TEL:
	FAX:

PATIENT DETAILS

Type of referral (Please tick) PIC HDU Male HDU Female

Surname:	Forename:
Address:	
DOB:	TEL:
MHA Status:	Date of Detention:
Diagnosis:	Date of Expiry:
CPA/117 Arrangements	

CYGNET HOSPITAL WYKE REFERRAL FORM

AUSTEN WARD (male only) fax to 01274 604600
BRONTE WARD (female only) fax to 01274 601300
SHELLEY WARD (male only) fax to 01274 600199

Reason for referral:

Has patient a history of :

Drug/Alcohol abuse	Yes/No	Self Harm	Yes/No
Violence	Yes/No	Arson	Yes/No
Forensic History	Yes/No	Psychiatric History	Yes/No

Details:

Current Presentation:

Is patient suicidal:	Yes/No	Aggressive	Yes/No
Absconding:	Yes/No	Compliant with treatment	Yes/No

Details:

Does patient require Specialling: Yes/No

Current Medication:

Does patient Have any Physical Needs:

Details: