**Referral Information**
**Call** 0808 164 4450
**Email** chcl.referrals@nhs.net

# Referral Form

## Service and placement required

☐ PICU/Acute ☐ Secure Services ☐ Mental Health Rehabilitation ☐ Personality Disorder
☐ CAMHS ☐ Eating Disorder ☐ Learning Disabilities ☐ Autism Spectrum Disorder
☐ Neuropsychiatric Services ☐ Older Adults ☐ Deafness and Mental Health

## About you

Name: _____

Job title: _____

Email address: _____

Telephone: _____

CCG: _____

Funder's name: _____

NHS number: _____

Reason for referral and specific expected outcomes (clinical and social). Please also state any risks:

_____

_____

## About the individual

Name: _____

Date of birth: _____

Gender: _____

Address of current placement: _____

_____

_____

Responsible clinician: _____

RC's email address: _____

RC's telephone: _____

Ward name: _____

Ward telephone: _____

Diagnosis: _____

Is the individual detained under the Mental Health Act?
**If yes, please supply section no:**

Yes _____ ☐ No

IQ (if applicable): _____

This referral form needs to be filled in and agreed by a healthcare professional only.

**Thank you, we will contact you shortly**

Important note: If CPA, tribunal, forensic or social circumstances reports are available, please email them to our MDT team on **chcl.referrals@nhs.net**

**For office purposes only**

Commissioning Manager: _____

Units to be considered: _____

_____

_____