Sample referral forms

**CRITERIA FOR REFERRAL (YOU MUST TICK ONE OR MORE BOXES)**

|  |  |
| --- | --- |
| **RISK** | |
| Suicidal |  |
| Harm to others |  |
| Self-neglect |  |
| **LACK OF RESPONSE TO TREATMENT IN PHC** | |
| Not improved following full treatment protocol in PHC |  |
| Worsening while on full treatment protocol in PHC |  |
| **COMPLICATED MANAGEMENT** | |
| Diagnosis uncertain |  |
| Comorbid physical health conditions |  |
| Comorbid substance misuse |  |

**NATURE OF REQUEST (INDICATE BY TICKING ONE BOX FOR EACH SECTION)**

|  |  |
| --- | --- |
| **TYPE OF RESPONSE REQUESTED** | |
| Case discussion with specialist |  |
| Referral for assessment and treatment advice |  |
| **URGENCY OF RESPONSE REQUESTED** | |
| Urgent response needed today (reasons should be clearly stated in Referral Information) |  |
| Response needed within one week |  |
| Routine |  |

**PATIENT DETAILS**

|  |  |
| --- | --- |
| **NAME AND STATUS** | |
| Full Name |  |
| Sex |  |
| Title |  |
| Date of Birth (DD.MM.YYYY) |  |
| Marital status (Circle one) | Single Married Separated Divorced Widowed |
| Religion |  |
| Ethnic group |  |
| **PATIENT’S CONTACT DETAILS** | |
| Address |  |
| Telephone number |  |
| First/preferred language |  |
| What is best way to contact patient? |  |
| **NEXT OF KIN** | |
| Name of next of kin |  |
| Relationship to patient |  |
| Address |  |
| Telephone |  |

**REFERRAL INFORMATION**

|  |  |
| --- | --- |
| **CASE HISTORY** | |
| Brief description of problem(s)  (include duration of present episode at first contact) |  |
| Current psychiatric symptoms |  |
| Treatment of current problems (medication or other therapies; include dose, duration and response) |  |
| Contributory factors (e.g. life events, alcohol, substance misuse, adherence issues etc.) |  |
| Past psychiatric history (including previous treatment) |  |
| Physical illness (including current medication) |  |
| **RISK TO SELF OR OTHERS (CIRCLE YES/NO; IF YOU ANSWER YES TO ANY QUESTIONS, PLEASE GIVE BRIEF DETAILS)** | |
| Are there current/recent suicidal ideas/acts? | YES / NO |
| Is there a history of self-harm? | YES / NO |
| Are you concerned about self-neglect? | YES / NO |
| Is there a history of threats or violence to others? | YES / NO |
| Is there any forensic history? | YES / NO |
| Is there a risk to children? (e.g. neglect, emotional deprivation, physical or sexual abuse) | YES / NO |
| Is there anything else you wish to inform us of? | YES / NO |

**REFERRER INFORMATION**

|  |  |
| --- | --- |
| **PRIMARY HEALTH CARE** | |
| Name of PHC centre |  |
| Address |  |
| Telephone |  |
| **REFERRER** | |
| Your name |  |
| Signature |  |
| Your designation |  |
| Date of referral |  |
| Is the patient aware that a referral is being made? | YES / NO (if NO, please give reason) |

**CASE SUMMARY CASE NUMBER**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_ Gender: M / F  Village: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(next of kin)* |
| Mental health diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(e.g. Depression)* |
| Physical health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Amount of money spent on alcohol and/or drugs per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ability to take care of self: 1 ................. 2 ................. 3 ................. 4 ................. 5  *(washing, eating, dressing etc.)*  can do all by self can do none alone  Personal strengths: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(list three) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family support: 1 ................. 2 ................. 3 ................. 4 ................. 5  excellent not available  Family details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Risk of harm to self: 1 ................. 2 ................. 3 ................. 4 ................. 5  Low High  Risk of harm to others: 1 ................. 2 ................. 3 ................. 4 ................. 5  Low High  Emergency plan says: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Drug treatment Drug name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_  Date started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date to stop: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Therapy treatment Advice given on healthy lifestyle: Yes / No  Education about illness: Yes / No  Problem solving skills teaching: Yes / No  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does patient agree? Yes / No Does family agree? Yes / No  Date for next review: \_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ |