Dear Referring Doctor

The following will help us with the admission / assessment of the patient. Please complete sections where possible.

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| **PATIENT’S CONTACT DETAILS:** | **REFERRER DETAILS:** |
| NAME: | NAME: |
| ADDRESS: | ADDRESS: |
| DATE OF BIRTH: | FAX NO: |
| PHONE NO: | PHONE NO: |
| GENDER: MALE  FEMALE  | EMAIL: |

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| INSURANCE COVER: | YES:  NO:  |
| HEALTH INSURER: (Please tick appropriate box) | VHI  Laya  OTHER  |
| INSURANCE POLICY NUMBER (if available): |  |
| IS THIS PERSON CURRENTLY ATTENDING ANOTHER MENTAL HEALTH SERVICE / SPECIALIST? | YES:  NO:   If yes please specify: |
| IS THIS PERSON RELATED TO YOU IN ANYWAY? | YES:  NO:  |

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| REASON FOR REFERRAL: (please include current weight/height or BMI) |
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| DATE OF ONSET OF PRESENT COMPLAINT: |

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| **RISK ASSESSMENT** | | | |
| **When completing the risk assessment please consider the following; (If ticking a box please explain in the spaces provided)** | | | |
|  | Vulnerability | physical illness , disability , falls , poverty , financial distress , homelessness , lack of supports , bullying , harassment , stigmatization , exploitation , abuse ,decline in hygiene , poor self-care ,poor food intake  memory problems , confusion , Other   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Self-harm/suicide | previous suicide attempt(s) , previous self-harm , previous suicide in the family/circle of friends , ongoing suicidal ideation , suicidal gestures , hopelessness , major life changes or challenges , Other   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mental instability | intense and obvious symptoms of mental illness: overspending , risk taking behaviours , bizarre behaviours , sexual disinhibition , anger and aggression , impulsivity , increased alcohol/drug use not following medical or legal advice   Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Risk to others | previous violence , poor self-control when angry , antisocial tendencies , possession of or access to weapons , Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| PAST PSYCHIATRIC HISTORY: (Please include copies of previous correspondence, details of previous admissions, details of previous medication or psychological treatments, if available) |
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| PAST MEDICAL & SURGICAL HISTORY: |
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| RELEVANT FAMILY HISTORY AND CURRENT SOCIAL CIRCUMSTANCES: |
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| CURRENT MEDICATIONS (Please include doses): |
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| HISTORY OF ADDICTIONS / SUBSTANCE ABUSE / GAMBLING / EATING DISORDER: |
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| LEGAL HISTORY: |
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| SIGNED: DATED: |

**Please include with referral:**

**1. Recent blood results (full blood work, including: TSH, LH, FSH, lipids, glucose),**

**2. ECG results,**

**And referral made to a Gastroenterologist for consultation (results from this not needed as assessment stage, just for admission).**