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).**