**Mental Health Triage and Assessment Team  
Routine referral triage request**

**Please read the following before proceeding with your referral:**

* *This service is for routine referrals only, if your query is urgent or there is an imminent risk of harm, please contact the service on the professional enquiry line (01482 216624), available 24/7 or emergency services.*
* *Please note this service is for adults aged 18 to 64 years only, with a Hull or East Riding GP.*
* *Please complete all fields of the form as it will not be processed if there is missing information. Only referrals received on this form will be processed and other documentation should only be sent as supplementary to this.*
* *Once complete, please forward this form by email to* [*hnf-tr.mhtat@nhs.net*](mailto:hnf-tr.mhtat@nhs.net)
* *Once received by the service, the referral will be screened and you will be advised of the outcome. If the referral does not require further triage you will be informed of this and the most appropriate service if applicable. If the patient is booked for a routine triage appointment, you will be made aware of the date and time of this and you (the referrer) need to inform the patient of this appointment.*

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| **First name:**  Preferred name if different: | **Last name:**  Preferred name if different: |
| **NHS Number:** | **Date of birth:** |
| **Current Address of patient:** | **Patients telephone/mobile telephone:**   (Please ensure this number is working and able to receive calls) |
| **Next of kin**  Name:  Relationship to patient:  Address:  Telephone number: | **GP details**  Practice name:  Named GP is applicable:  Address:  Telephone number: |
| **Referrer details**  Name:  Role:  Address:  Telephone number:  Email address: | **Details of other services involved with the patient:** |

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| --- | --- |
| **Is the patient aware of and consenting to the referral?**  **Y/N (please indicate)** | Yes – please continue with referral  No – if the patient is not aware of the referral or consenting to it, the referral will not be processed. Please phone the professional enquiry line for discussion. |
| ***Please indicate any preferred days and times the patient is available for telephone triage:*** |  |
| ***Current mental health presentation (please include risk to self or others):*** | |
| ***Current and historical mental health involvement/treatment/interventions:*** | |
| ***Current social factors impacting on situation:*** | |
| ***Current and historical substance use:*** | |
| ***Please indicate any significant medical history, allergies and all current prescribed medication:*** | |
| ***Any other information you feel is important to the referral:*** | |
| ***Please indicate what you and/or the patient is seeking from the referral:*** | |

**\*Expand sections as required\***