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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:** | **Is the patient aware of and consenting to the referral?**  (Please note, if answered no, the referral may be rejected. If the patient does not have capacity to consent to the referral, please contact the service by phone) |
| **Referrer details**  Name:  Role:  Contact address and Telephone Number: | **GP details (if different from referrer)** |

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| **Date of referral:**  **Service being referred for Adult Mental Health Older Peoples MH Services** |
| **Referrer priority status**  **Please use referral from for routine referrals only and send to hnf-tr.mhrs@nhs.net. If you referral is urgent, you must contact the team directly to refer on 01482 301701.** |
| **Mental health presentation (include signs and symptoms, including historical presentation)** |
| **Risk of harm to self (include intentional/unintentional harm)** |
| **Social Factors( include social network, employment, children)** |
| **Relevant physical health needs and ALL prescribed medication** |
| **Please indicate the support you and/or the person being referred is seeking:**   * **Primary care talking therapies/IAPT (Let’s Talk/EWS)** * **For medication advice only** * **Secondary care mental health assessment** * **Community mental health team** * **Early intervention in psychosis** * **Memory assessment** * **ADHD assessment (Hull GPs only to refer)** * **Drug & alcohol services – Refer to ReNew or East Riding Partnership (this includes if there is some moderate mental health needs)** * **Social care assessment – Refer to local authority** |
| **Any other relevant information/other agencies involved** |