 

PATHWAY DEVELOPMENT SERVICE

HOSPITAL REVIEW REFERRAL FORM

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| **Date Received:** | **Referral No:****NHS No:****Care Director No:** |
| 1. **SERVICE USER DETAILS**
 |
| Name: | Male [ ]  Female [ ]  |
| Date of Birth: | Age: |
| Civil Status:Employment Status: | Any Physical Disabilities:First Language:Religion: |
| Where does the client reside in the community?”NFA or temporary accommodation?Supported Accommodation? – if yes please include name of provider.Own Tenancy- Private rented?Own tenancy – Local Authority?Live with family? – if yes is this environment suitable for the client? | Hospital Address (including postcode):Type of Unit: |
| Name of Responsible Clinician:Tel NoName of Community Psychiatrist:Tel No | Name of Care co-ordinator:Tel No |
| GP Name & Address: |  |
| Is the service user aware that they have been referred? | Yes/No |
| 1. **REFERRER DETAILS**
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| Name: | Referrer’s Position: |
| Contact Details: |  |
| **ANY OTHER SIGNIFICANT WORKERS INVOLVED***Please include names, addresses, telephone numbers and email addresses where known* |
| 1.2.3.4. |
|  |  |
| 1. **Other significant information:**
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| MHA Status: | Date of Detention: |
| Current agency/service involvement:Has the service user been previously admitted to a specialist personality disorder inpatient service?**This section MUST be completed. The referral may be returned if not.**If Yes, please specify name of hospital(s) and date(s) | Date of next CPA Meeting:Date of next MHRT/Managers Hearing:Yes/No |
| 1. **Service User Characteristics**
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| *Please consider emotional & behavioral difficulties inc managing emotions, relationships, problem solving etc* |
| 1. **Staff/Service Issues**
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| *Please include issues the clinical team have when working with / managing the individual and any resource issues* |
| 1. **Risks to self/others**
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| *Please include specific and known risks to others or self (including vulnerability).Please attach relevant risk assessments* |
| 1. **Mental Health History**
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| *Please include diagnoses, clinical presentation, contact with services, previous admissions, substance misuse, treatments etc* |
| 1. **Pathway Issues**

**This section must be completed. Referrals will be returned if not completed.** |
| *Please include the current concerns about pathways for this service user including risk of entering secure care or ‘blocked’ pathways whilst currently in secure care. Please attach any relevant CPA documentation* |

**Contact Details:**

Completed referral forms should be returned to:

Pdreferrals.lypft@nhs.net

For more information or to discuss a potential referral, please contact Hayley Brown or Mark Naylor on Tel 0113 8557950 or via email hayley.brown3@nhs.net or marknaylor@nhs.net

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| PATHWAY DEVELOPMENT SERVICE**YOUR REFERRAL MAY NOT BE PROCESSED IF YOU DO NOT COMPLETE THIS SECTION.**Equal Opportunities Monitoring Form  (AT REFERRAL STAGE) |
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| In order to monitor policy, and for that reason only, we would ask you to complete the following questions. |
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| Is the person | Male |[ ]  Female | [ ]  | Other (please state) [ ]  |
| Gay |[ ]  Lesbian |[ ]  Other (please state) [ ]  |
| Heterosexual |[ ]  Bi-sexual | [ ]  |  |
|  |
| **Ethnicity – would you describe the client as:**(please choose ONE section from A to E, then tick the appropriate box to indicate your cultural background) |
| 1. **White**
 | **B. Blackor Black British** | C. Asian or Asian British | D. Dual Heritage  | 1. **Chinese or other Ethnic Group**
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|  |  |  |  |  |
| [ ]  British [ ]  Irish [ ]  Other (state) | [ ]  Caribbean[ ]  African[ ]  Other (state) | [ ] Indian[ ]  Pakistani[ ]  Bangladeshi[ ]  Other (state) | [ ]  White/Black Caribbean[ ]  White/Black African[ ]  White/Asian[ ]  Other (state) |  [ ]  Chinese  [ ]  Other (state) |
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**The Pathway Development Service thanks you for your assistance in completing this monitoring form.**