Mental Health Services Referral

All referrals to be made via email to: TEWV.yorkaccesspoint@nhs.net

For ALL crisis referrals you should call 01904 526582

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| --- | --- |
| Date Of Referral |  |
|  |
| Service Being Referred For | Adult MH | Older People Services |
| *Please note for IAPT referrals please ask the patient to self-refer by phoning 01904 556820* |
|  |
| **Person Being Referred** |
| Name |  | D.O.B |  |
| NHS Number |  | Ethnicity |  |
| Contact Tel. No (s) |  | Preferred Language |  |
| Accommodation Status |  | Employment Status |  |
| Address & Post Code | Current Address & Post Code (if different) |
|  |  |
| Is the individual aware of and consenting to the referral | Yes | No |
| What is the individual’s preferred method of contact |  |
| If phoning the individual, are we able to leave a voicemail? | Yes | No |
|  |
| **Next of Kin / Emergency Contact / Carer Details** |
| Name |  | Address (if different) |
| Relationship |  |  |
| Contact Tel No. |  |
| Has consent been given for services to contact this individual? | Yes | No |
|  |
| **GP Details** |
| Name |  | Address (of registered practice) |
| Tel No. |  |  |
| Email: |  |
|  |
| **Referrer Details (If different from GP)** |
| Name | Address |
| Tel No. |  |
| Email: |
|  |
| **Reason for Referral** |
| **What are the mental health concerns including details of risk and safeguarding?****What is the individual requesting?** |
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| **Medication & Test Results** |
| **Please list current medications and details of any known allergies / sensitivities. Please also detail any recent test results / investigations.** |
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|  |
| **If possible please enclose/attach a copy of the summary care record** |