Mental Health Services Referral

All referrals to be made via email to: [TEWV.yorkaccesspoint@nhs.net](mailto:TEWV.yorkaccesspoint@nhs.net)

For ALL crisis referrals you should call 01904 526582

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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?** | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Medication & Test Results** | | | | | | | | | | | |
| **Please list current medications and details of any known allergies / sensitivities. Please also detail any recent test results / investigations.** | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **If possible please enclose/attach a copy of the summary care record** | | | | | | | | | | | |