

REFFERAL FORM

All submissions to refer@vineyard-care.co.uk

This form is to be completed by professional referrers only (i.e. Doctor, Registered Mental Health Nurse, Social Worker, Occupational Therapist, Care Services Managers). We recommend that the referrer engages patients views wherever possible.

PERSONAL DATA (PATIENT)											
First Name:				Middle N	lame:						
Surname:				Date of E	Birth:						
						D	D	М	Μ	Υ	Υ
Gender: Ma	le F	emale		Other						Spe	cify
Marital Status:	Single	Marri	ied	Divorce		Wid	ow/e	r	C	Other	
Current Inpatient:	N/A	Rehabilita	ation	Acute w	vard		PICU		LS	U	
Community settin	g (Current/	'Recent): Ald	one (Flat	t/House)		Share	d with	n oth	ers	1 2	3+
National Insurance No.:				Telep	hone N	10:					
First Language:				Int	terpret	er rec	quir.eo	y k		N	
									_		
NEXT OF KIN D	ETAILS										
Full Name:				Relations to Patier							
Full Address:											
Postcode:				City/Count	ty:						
Email Address:				Telephone N	lo:						

COMMUNITY MENTAL HEALTH PROFESSIONAL /CARE COORDINATOR

Name of Consultant/ Social Worker	
Office Address	
Telephone No:	
Email Address:	

MENTAL HEALTH MULTIAXIAL

Axis I (Active Mental Disorder/s):

Axis II (Personality Disorders/ Intellectual disabilities):

Axis III (Physical Health conditions)

Axis IV (Psychosocial/ Environmental stressors)

Axis V (Global Assessment of Functioning) 0 to 100



SYMPTOM HISTORY (Part of our Enhanced Psychosis Pathway)						
	Recent Episode of illness	Past Episode/s of illness	Never	Further Details (Date/Year)		
Command Auditory Hallucinations						
Other Auditory Hallucinations						
Persecutory delusion						
Passivity phenomenon						
Weapon carrying associated with Psychosis						
Assault of others associated with Psychosis						
Psychomotor agitation						
Impulsivity						
Hopelessness/ Helplessness						

PERSONAL CARE NEEDS (See Rating Guide)

	High Support	Medium Support	Low Support	No Support
A - Personal Hygiene/Bathing:				
B - Dietary needs/Cooking				
C - Medication Compliance:				
D - Meaningful routines/Wellness:				

HOUSING SUPPORT NEEDS (See Rating Guide)

	High Support	Medium Support	Low Support	No Support
A – Budget/ Finance:				
B – Shopping:				
C – Utility Bills:				
D – Maintaining Tenancy:				

COMMUNITY ACCESS NEEDS (See Rating Guide)

	High Support	Medium Support	Low Support	No Support
A – Transport/Road awareness:				
B – Vulnerability to Exploitation:				
C – Social Skills/Anxiety:				
D – Group Activities/Appointments:				

OTHE	OTHER AREAS OF BASIC SUPPORT (Tick)						
	Reading/Writing		Other				
	Number Skills		None applicable				
	Communication Language						

Additional Comments:

Details of any Outstanding Debts:

Subject to 117/Aftercare :	YES	NO
If Yes, Last Section 3 Discharge: Current Adm	ission	Date:
Requirement for CTO Identified:	YES	NO
Requirement for Appointeeship identified:	YES	NO

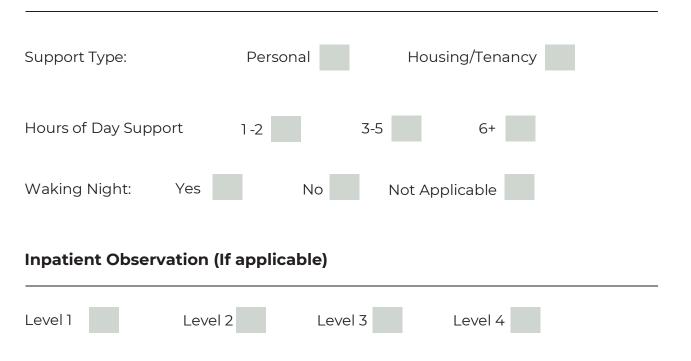
RISK HISTORY (Risk from Others)					
	Current Less than 12 months	Past 12 months or more	Never	Further details	
Sexual exploitation					
Financial exploitation					
Domestic abuse					
Physical Harm/ Assault					
Theft/Scams					
Bullying/Control					
Racially motivated incidents					
Emotional abuse					
Other risks (Specify)					

RISK HISTORY (Risk to Health and Safety)					
	Current Less than 12 months	Past 12 months or more	Never	Further Details	
Alcohol Misuse/Addiction					
Illegal Drug Use/Addiction					
Legal Highs					
Poor Healthcare					
Self Neglect					
Suicidal Thoughts (No attempts)					
Deliberately Self Harming					
Suicide Attempt					

RISK HISTORY (Risk to Others)					
	Current Less than 12 months	Past 12 months or more	Never	History of Caution/ Convictions	
Public Disorder offences					
Sexual Offences					
Sexual Offences against children					
Arson					
Firearms/ Weapon carrying					
Theft or burglary attempt					
Criminal Damage					
Threatening or Verbal Aggression					
Racially motivated incidents					
Physical violence/ assault/ABH/GBH					
Aggression directed to staff in the course of care delivery					
Murder or manslaughter					

HIGHEST LEVEL OF INPATIENT OBSERVATION AND/OR COMMUNITY SUPPORT (Within the last 4 weeks)

Community Support (If applicable)



Note: Level 1= Hourly, Level 2= 5 to 30 minutes, Level 3= Eye sight, Level 4= Arms Length

DETAILS OF THE REFERRER

NAME:	ROLE:	
ADDRESS:	TELEPHONE:	

The information entered is of highest accuracy and attention, to the best of my knowledge.

SIGNATURE:	
DATE:	

Please submit completed form to: refer@vineyardcare.co.uk

FOR SERVICE USE ONLY

REFERRAL ACCEPTANCE OR REJECTION		
What is primary support need?		
	YES	NO
Mental Health		
Substance Misuse		
Physical		
Housing		
Accept referral and proceed to assessment?		

We exclude referrals whose primary reasons are Housing or Physical health.

Explanation of reason, if rejected: