|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| YHST Logo Black And White | | **MENTAL HEALTH**  **RECOVERY TEAM**  **REFERRAL FORM** | | | | **30 Clarence Street, York, YO31 7EW**  Telephone: (01904) 553850  [MHRSenquiries.30ClarenceSt@york.gov.uk](mailto:MHRSenquiries.30ClarenceSt@york.gov.uk) | | | | |
|  | |  | | | |  | | | | |
| Referrers Name:  Telephone Number:-  Email:-  Mobile Number:- | | | | | Date of referral | | | | Admission date | | |
| NHS Number | | P Number | | | | Mosaic Number | | | | CPA  Non-CPA | |
| Forenames(s) | | | | Surname | | | | AKA | | | Title |
| HOME ADDRESS: | | | | | | DOB: AGE: M/F | | | | | |
|  | | | | | | SIG OTHER: | | | | | |
|  | | | | | | RELATIONSHIP: | | | | | |
|  | | | | | | RELIGION: | | | | | |
| POSTCODE: | | TEL: | | | | ETHNICITY: | | | | | |
| CURRENT ADDRESS: | | | | | | LANGUAGE SPOKEN: | | | | | |
|  | | | | | | EMPLOYMENT: | | | | | |
|  | | | | | | CHILDREN/DEPENDENTS | | | | | |
|  | | | | | |
| POSTCODE: | | TEL: | | | |
| NEXT OF KIN: | | | | | |  | | | | | |
| RELATIONSHIP: | | | | | | CONSULTANT: | | | | | |
| ADDRESS: | | | | | | GP: | | | | | |
|  | | | | | | SURGERY: | | | | | |
|  | | | | | |  | | | | | |
| POSTCODE: | | TEL: | | | | POSTCODE: | | | | TEL: | |
| CPA CARE COORDINATOR | | | | | AGENCY | | | | TELEPHONE | | |
|  | | | | |  | | | |  | | |
| OTHER PROFESSIONALS INVOLVED IN CARE | | | | | | | | | | | |
|  | | | | | | | | | | | |
| NAMED NURSE: | | | | | | WARD: TEL: | | | | | |
| OCCUPATIONAL THERAPIST: | | | | | | WARD: TEL: | | | | | |
| Reason for referral | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Clients perspective about the referral (this can be completed by the client) | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Details of Admission | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Brief past psychiatric history (Please enclose recent discharge summary or MHA report if possible) | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Risk Issues: **(1) Up to date SAMP required for referral to be proc**  **(2) No SAMP attach an alternative up to date risk assessment** | | | | | | | | | | | |
| Managing mental health  ( What are the current mental health issues, how does the person manage them) | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Use of alcohol or drugs | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Employment/work experience | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Physical health | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Current problem list | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Signature of referrer | | | | | | | | | | | |
| For Official Use Only  Date Received:-  Receiving Officer:- | | | | | | | | | | | |
| **Service referred to**  **Training Scheme Cafe or Reception Easy Budget Meals**  **Advice & Guidance Community Groups**  **Baking Groups**  **Well Being groups** | | | | | | | | | | | |
| Notes: | | | | | | | | | | | |