

**Mental Health Act 1983 Referral Form A V2**

**This form should only be completed if an assessment under the Mental Health Act (MHA) 1983 is required. Please note any referrals for a Community Treatment Order, Guardianship or regrade for individuals already detained under the Act should be completed on Form B.**

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| **Details of the individual being referred** |

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| **Individuals name:** |  | **Individuals home address:** |  |
| **Preferred name:** |  | **Date of birth:** |  |
| **Gender at birth:** |  | **Individuals contact number:** |  |
| **Gender individual identifies as:** |  | **Individuals’ current location:** |  |
| **NHS Number:** |  | **LAS Number:****(If known)** |  |
| **Ethnicity:** |  | **Does the individual need an interpreter/signer?** |  |
| **Preferred language:** |  | **Is the individual aware of the referral?** |  |

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| **Referrer details** |

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| **Referrer name:** |  | **Referrer address:** |  |
| **Referrer job title:** |  | **Referrer contact number:** |  |
| **Referrer email address:** |  | **How long has the referrer known the individual:** |  |

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| **Next of Kin Information** |

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| **Name:** |  | **NoK address:** |  |
| **Relationship:** |  | **NoK contact number:** |  |

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| **Nearest Relative Information (If known)** |

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| **Name:** |  | **NR address:** |  |
| **Relationship:** |  | **NR contact number:** |  |

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| **GP/Health Information** |

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| **GP name:** |  | **GP contact number:** |  |
| **GP address:** |  | **Date the individual last saw GP:****(If known)** |  |

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| **Does the individual have any known physical health conditions/comorbidities?** |  |

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| **Mental Health Services Involvement (If known)** |

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| **Team name:** |  | **Responsible clinician:** |  |
| **Named professional:** |  | **Team contact number:** |  |
| **Does the individual have a MH diagnosis (please state):** |  | **Does the individual have a drug/alcohol dependency? (If yes, provide brief details and confirm if fit for an assessment:** |  |
| **Is the individual subject to s117?** |  | **LA and ICB (integrated Care Board) with s117 responsibility:** |  |

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| **Has the individual previously been admitted to a psychiatric hospital? (Please provide dates/brief history):** |
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| **Referral Information**  |  |
| **When was the individual last seen, by whom and what was the outcome of this visit:** |  |
| **Has the individual been medically reviewed and is there a medical recommendation:** |  |
| **If there are any known triggers leading to the episode of mental ill health:** |  |
| **Please provide details of which least restrictive options have been offered and implemented prior to this referral (i.e., HTT, Crisis Team) and outcomes and dates of interventions:** |  |
| **Has the individuals Capacity been assessed and documented:** |  |
| **(If the individual has capacity) Has an informal admission been discussed with the individual, if so, provide outcome of discussion, if not please state rationale:** |  |
| **Has a Local Area Emergency Protocol meeting/CETR been convened for people with ASD/LD, provide details:** |  |
| **Has the bed been sourced (provide details):** |  |
| **Does the individual have pets and if so, have arrangements been made should they be admitted:** |  |
| **Please provide more detail as to the purpose for this request:** |  |
| **Risk Management** |  |
| **What are the current and immediate risks to the individual:** |  |
| **What are the current and immediate risks to others:** |  |
| **Are there any significant risk history factors (i.e., violence/weapons):** |  |
| **Is the individual vulnerable to other forms of risk (i.e. self-harm, self-neglect, exploitation by others):** |  |
| **Is a safeguarding referral required? If yes, has this been completed (please include date/time of referral):** |  |
| **Does the individual care for/have contact with children? (E.g., parent, teacher etc):** |  |
| **Referring to the risk threshold matrix (pg 4), how would you rate the current level of risk (please state red, amber, or green):** |  |
| **Referral completion details** |  |
| **Date and time referral completed:** |  |
| **Referrer, please sign name to confirm that the information contained in this report is accurate and up to date regarding the individual circumstances and individual referred:** |  |

**Please note, if the individual is known to mental health services, the referrer is required to send the latest copy of the GRIST and Crisis Plan.**

**Please send the completed Referral Form to** **amhpteam@worcestershire.gov.uk**

**Telephone contact details: 01905 846877**



**Risk Threshold Matrix**

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| **Referral category** | **Current presentation** |
| **Red: Immediate High Risk**Significant Harm to self and or others.Severe behavioural disorder with immediate threat of dangerous and violent behaviour. | Recent violent behaviour and/or history of violence when unwell (both to self and/or others)Possession of weapon Extreme agitation or restlessness Bizarre/disoriented behaviour Acutely psychotic or thought-disordered Situational crisis, deliberate self-harm Agitated/withdrawn Receiving verbal commands to harm self or others that the person is unable to resist (command hallucinations) Recent violent behaviour is unable to resist (command hallucinations) Refusal of treatment/intervention/support |
| **Amber: Moderate Risk** Possible risk of harm to self and / or others  | Moderate agitation/restlessness Verbally aggressive/threat of harm to others Intrusive behaviour Confused/unable to cooperate Hallucinations/delusions/paranoia Attempt at self-harm/threat of self-harm Agitation/Restlessness Ambivalent about treatment or not likely to wait for treatment Suicidal ideation Situational crisis Hallucinations Delusions Paranoid ideas Thought disordered Bizarre/agitated behaviour Severe symptoms of depression Withdrawn/uncommunicative and/or anxiety Elevated or irritable moodPatient refusing intervention/supportPatient does not have capacity to make informed decision regarding their current care and treatment |
| **Green: Mild to Moderate Risk**No immediate risk to self or others but making threats of self-harmNo acute distress or behavioural disturbance Known patient with chronic symptoms  | Mild tomoderate levels of agitation/restlessness Irritable without aggression Cooperative Gives coherent history Pre-existing mental health disorder Symptoms of moderate anxiety ordepression Moderate evidence of cognitive impairmentAmbivalent towards intervention/supportCooperative/Communicative and able to engage in developing management plan Able to discuss concerns/Compliant with instructions Known patient with chronic psychotic symptoms Pre-existing non-acute mental health disorder Known patient with chronic unexplained somatic symptoms Request for medication Minor adverse effect of medication Financial, social, accommodation, relationship difficulties |