

Referral Form
(Mental Health Services SJH)

Date of Referral ____/____/____

Client's name: _____

D.O.B: ____/____/____

Address: _____

Telephone No: _____ **Mobile** _____

Next of Kin: _____

Address: _____

Telephone No: _____ **Mobile** _____

Reason for Referral (Please include presenting complaints, brief mental health, history, working diagnosis):

Current Medication: _____

Medical History: _____

Currently aggressive or violent?

Yes () or No ()

Social Circumstances (Please include occupation, relationships with family and friendly, housing , etc.): _____

Forensic History: _____

**Our service should contact within <24 hours () ; or 1-3 days () ;
or 1-2 weeks () : or 3-4 weeks ()**

Referral Agency – Name: _____

Address: _____

Telephone No: _____ **Mobile:** _____

E-mail: _____

OFFICE USE ONLY:	Date referral received: __/__/__						
St James's MRN							
Urgency:		24Hours () <u>or</u>		72Hours () <u>or</u>		Elective ()	
Special Risk Factors:							
Action Taken:		Discussed with referrer ()		other			
Key Worker:							
Date: ____/____/____		Time:					
Signed:							