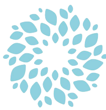
St Patrick's
Mental Health Services



RECOMMENDATON FOR INVOLUNTARY ADMISSION REFERRAL FORM

***Please complete in full and return to* Assessment Unit by fax at 01- 2493609**

For further enquiries please contact 01-2493635 or 01-2493640

Patient's Contact Details:	Referrer Details
Name:	Name:
Address:	Address
DATE OF BIRTH:	FAX NO:
PHONE NO:	PHONE NO:
GENDER: Male [ ] Female [ ]	EMAIL:
INSURANCE COVER	YES ☐ NO ☐
HEALTH INSURER (Please tick appropriate box)	VHI ☐ QUINN ☐ AVIVA ☐ OTHER ☐
INSURANCE POLICY NUMBER:	

REASON FOR REFERRAL (Please include current mental state of individual)
DATE OF ONSET OF PRESENT COMPLAINT:
HAS THE PERSON SEEN YOU OR ANOTHER CLINICIAN IN RELATION TO THIS OR ANOTHER MENTAL HEALTH CONDITION PREVIOUSLY? YES ☐ NO ☐ DON'T KNOW ☐
PAST PSYCHIATRIC HISTORY (N.B. Please include copies of correspondence)

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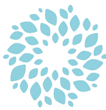

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PREVIOUS ADMISSIONS TO SECURE SETTING: YES ☐ NO ☐
If YES, give details:
PAST MEDICAL & SURGICAL HISTORY ***(N.B. Please provide all relevant details)***
FAMILY / SOCIAL HISTORY:
MEDICATIONS:

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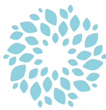

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HISTORY OF ADDICTIONS (Please give details of misuse of drugs or alcohol)				
RISK ASSESSMENT ***The information requested below is essential to ensure the wellbeing and safety of the service user and the authorised person during an involuntary admission.*** ***Pleas give as much information***				
A. MENTAL HEALTH RISK ASSESSMENT				
1. RISK TO SELF	YES	☐	NO	☐
HISTORY OF DELIBERATE SELF HARM	YES	☐	NO	☐
If yes to any of the above, please give details;				
2. RISK TO OTHERS	YES	☐	NO	☐
PREVIOUS INCIDENTS OF VIOLENCE	YES	☐	NO	☐
If yes to any of the above, please give details;				
PREVIOUS USE OF WEAPONS	YES	☐	NO	☐
If Yes please give details;				

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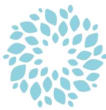

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PREVIOUS DANGEROUS, COMPULSIVE ACTS	YES ☐	NO ☐
Give details		
3. FORENSIC HISTORY	YES ☐	NO ☐
If YES, give details;		
B. MEDICAL RISK ASSESSMENT:		
1. CARIDAC ISSUES (History of heart condition etc)	YES ☐	NO ☐
If yes to any of the above, please give details;		
2. MOBILITY ISSUES (Wheelchair, walking aide required)	YES ☐	NO ☐
If yes to any of the above, please give details;		
3. MOBILITY CHALLENGES (Prosthesis, Hip/Knee or other Joint Replacement)	YES ☐	NO ☐
If yes to any of the above, please give details;		

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4.HISTORY OF HEAD TRAUMA, PARKINSON'S, DEMENTIA	YES ☐	NO ☐
If yes to any of the above, please give details;		
5. HISTORY OF DIABETES	YES ☐	NO ☐
If yes to any of the above, please give details;		
6. RESPIRATORY ISSUES	YES ☐	NO ☐
If yes to any of the above, please give details;		
SIGNED:	**DATED:**	

PLEASE PROVIDE ANY ADDITIONAL RELEVANT INFORMATION:

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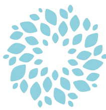

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