www.stpatrickshosp.ie

St Patrick's
Mental Health Services

GP REFERRAL FORM: ASSESSMENT FOR ADULTS SERVICES ST PATRICKS MENTAL HEALTH SERVICES

Please complete in full and return to the Referral & Assessment Unit:
St. Patrick's University Hospital, P.O. Box 136, James's St., Dublin, D08 K7YW
Tel: 01 249 3635 Fax: 01 249 3609

All referrals to our Adult Services are reviewed by our Referral & Assessment Clinical team and allocated to the most appropriate service. What service do you believe would be best meet the patient's needs?

Assessment for Inpatient Admission: ☐
Dean Clinic Assessment: ☐
Assessment for Other Services ☐

All referrals for Non-Inpatient Services* will receive a Free of Charge Prompt Assessment of Needs, by an experienced Registered Mental Health Nurse.
**For details regarding St Patrick's Non-inpatient services, please refer to our website. These include but are not limited to Day services, the Dean Outpatient clinics and psychotherapies.*

PATIENT CONTACT DETAILS:

Name: _____

Address: _____

_____

Date of Birth: ___/___/___ **Telephone:** _____ **Gender: F / M**

REFERRER'S CONTACT DETAILS:

Name: _____

Address: _____

_____

Telephone No.: _____ **Fax No:** _____ **Email:** _____

Reason for Referral:

Date of Onset of Present Complaint: / /

Is the person you are referring currently under the care of a psychiatrist or another mental health service? ☐ YES ☐ NO

If you answered YES to the above question, please choose <u>one</u> of the options below:

☐ Requesting Transfer of Care to St Patrick's Mental Health Services

☐ Referring for a second opinion

Risk to self: ☐ YES ☐ NO (If Yes, please provide detail):

Risk to others: ☐ YES ☐ NO (If Yes, please provide detail):

Past Psychiatry History *(Please include copies of the correspondence)*:

Past Medical & Surgical History:

Family & Social History:

History of Addiction and Forensics:

Medications:

Additional Information:

BLOOD RESULTS REQUIRED FOR DAY OF ASSESSMENT:

FBC: TFTs: Renal & LFTs:

INSURANCE DETAILS:

Health Insurance: YES ☐ NO ☐

Health Insurance Provider (*tick relevant insurer*):

☐ VHI ☐ Quinn ☐ AVIVA ☐ LAYA ☐ Other (*Please state*)

Policy Number:

I understand that I retain clinical responsibility for this patient until they are seen by St Patrick's Mental Health Services.

Signed: _____ **Date:** _____

How did you hear about our service: ☐ Media ☐ Literature ☐ Other: