GP REFERRAL FORM: ASSESSMENT FOR ADOLESCENT 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 3687 Fax: 01 249 3609

All referrals to our Adolescent 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 Adolescent Inpatient Admission: ☐

Assessment for Adolescent Outpatient services ☐

All suitable 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 the Dean Outpatient clinics and psychotherapies.*

YOUNG PERSON DETAILS:

Name: _____

Address: _____

_____

Date of Birth: ____/____/____ **Telephone:** _____ **Gender: F / M/ Other**

PARENTS CONTACT DETAILS

Mothers name: _____
Telephone: _____

Fathers name: _____
Telephone: _____

Address (if different from above) _____
_____

LEGAL GUARDIANSHIP

Sole ☐ Joint ☐ Care order ☐

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 child or adult 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):

History of Deliberate self-harm or suicidal ideation?

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

Past Psychiatry History (including admissions if applicable).

Past Medical & Surgical History:

Family & Social History:

History of Addiction/substance misuse and Forensics:

History of violence or aggression:

Medications (past and current):

If the referral is in relation to a possible eating disorder, please provide current BMI and a copy of any recent bloods or ECG

Additional Information:

INSURANCE DETAILS:

Health Insurance: YES ☐ NO ☐

Health Insurance Provider (*tick relevant insurer*):

☐ VHI ☐ Quinn ☐ AVIVA ☐ LAYA ☐ Other (*Please sta*

Policy Number:

I understand that I retain clinical responsibility for this patient until they are seen by St Patrick's Mental Health Services and will accept back care if they are admitted to Willow Grove Adolescent unit

I have consent from _____(parent(s)/guardian(s) for a member of St Patricks Mental Health Services adolescent referral team to make initial phone contact with one or both parents/guardians of the young person if required to conduct via telephone a prompt assessment of needs to help determine suitability for SPMHS

Signed: _____ Date: _____

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