www.stpatrickshosp.ie

St Patrick's
Mental Health Services

# GP REFERRAL FORM: ASSESSMENT FOR ADULT SERVICES
# ST PATRICKS MENTAL HEALTH ADULT 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:**

**Email Address:**

**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:

*Revised 22nd May 2020*