Referral Information
Call 0808 164 4450
Email chcl.referrals@nhs.net

Referral Enquiry Form

Service and placement required

☐ PICU/Acute ☐ Secure ☐ Mental Health Rehabilitation & Recovery ☐ Personality Disorder
☐ CAMHS ☐ Eating Disorder ☐ Learning Disabilities ☐ Autism Spectrum Disorder
☐ Neuropsychiatric Services ☐ Older Adults ☐ Deafness and Mental Health

About you

Name: _____

Job title: _____

Email address: _____

Telephone: _____

ICB: _____

Funder's name: _____

NHS number: _____

Reason for referral and specific outcomes:

About the individual

Name: _____

Date of birth: _____

Gender: _____

Address of current placement: _____

_____

_____

Responsible clinician: _____

RC's email address: _____

RC's telephone: _____

Ward name: _____

Ward telephone: _____

Diagnosis: _____

Is the individual detained under the Mental Health Act?
If yes, please supply section no:

Yes _____ ☐ No

IQ (if applicable): _____

This referral form needs to be filled in and agreed by a healthcare professional only.

Thank you, we will contact you shortly

Important note: If CPA, tribunal, forensic or social circumstances reports are available, please email them to our MDT team on **chcl.referrals@nhs.net**

For office purposes only

Business Relationship Manager: _____

_____

Units to be considered: _____

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