

Referral Enquiry Form

Service and placement required

PICU/Acute	Secure	Mental Health Re	habilitatior	n & Recovery	Personality Disorder
CAMHS	Eating Disorder	Learning Disc	Ibilities	Autism Spectru	m Disorder
Neuropsychiatric Services		Older Adults	Deafness	Deafness and Mental Health	

About you

Name:	Reason for referral and specific outcomes:
Job title:	
Email address:	
Telephone:	
ICB:	
Funder's name:	
NHS number:	

About the individual

Name:	RC's telephone:		
Date of birth:	Ward name:		
Gender:	Ward telephone:		
Address of current placement:	Diagnosis:		
	Is the individual detained under the Mental Health Act? If yes, please supply section no:		
Responsible clinician: RC's email address:	IQ (if applicable):		
This referral form needs to be filled in and agreed by a healthcare professional only.	For office purposes only Business Relationship Manager:		
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	Units to be considered:		