## Referral Information

Call 08081644450
Email chcl.referrals@nhs.ne†
Cygnet

## Referral Enquiry Form

## Service and placement required

$\square$ PICU/Acute $\square$ secure $\square$ Mental Health Rehabilitation \& Recovery $\square$ Personality Disorder $\square$ CAMHS $\square$ Eating Disorder $\square$ Learning Disabilities $\square$ Autism Spectrum DisorderNeuropsychiatric Services $\square$ Older Adults $\square$ Deafness and Mental Health

## About you

Name: $\qquad$

Job title: $\qquad$

Email address: $\qquad$
Telephone: $\qquad$

ICB:

Funder's name: $\qquad$
NHS number: $\qquad$

## About the individual

$\qquad$ RC's telephone: $\qquad$

Date of birth: $\qquad$ Ward name: $\qquad$

Gender: $\qquad$ Ward telephone: $\qquad$
Address of current placement: $\qquad$ Diagnosis: $\qquad$

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

Yes $\qquad$No

IQ (if applicable): $\qquad$
RC's email address: $\qquad$

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

