

## Referral Information

Call 0808 164 4450

Email [chcl.referrals@nhs.net](mailto:chcl.referrals@nhs.net)



# Cygnet Specialist Rehabilitation Referral Form

## About you

Name: .....

Job title: ..... Email address: .....

Date: ..... Phone no: .....

Funding ICB: ..... ICB contact: .....

Referring organisation: .....

## Clinical Information to Support Referral

**Please provide up to date clinical information to support assessment:**

Reports selected below should be attached to an email and sent with this form.

### Included

Y N

3 months' daily care notes

Up to date CPA reports (psychiatry, OT, psychology etc.)

Recent psychiatric contact and assessments including; home treatment team

Recent comprehensive risk assessment

Details of forensic assessments/history

### Included

Y N

Recent tribunal reports especially any upcoming within 5 days

HCR20

MHA documentation (copies of section paperwork)

AMHP report accompanying application (MHI)

Current medications chart

Current care plans

## About the individual

Name of Service User: .....

DoB: .....

Current diagnosis/es:

NHS number: .....

**About the individual...Continued**

Current placement details including full address, telephone number and ward name if applicable:

Current observation level:

Current leave status:

Current service type:

- Secure            High Support Inpatient Rehabilitation
- PICU             Community Residential
- Acute            Supported Living
- Home

Has patient required seclusion in past 4 weeks?            **Y**        **N**

Details of MHA section (if applicable) and expiry date:

Type of placement being sought (tick applicable):

- Mental health rehabilitation            Autism
- Complex trauma/personality disorder rehabilitation            Neuropsychiatric Services
- Learning disabilities                            Discharge to assess/transitional service

**Circumstances leading to current admission:**

**Objectives to be achieved by onward placement:**

Current RC name, contact number and email address:

Social Worker name, contact number and email address:

Care Coordinator name, phone number and contact email address:

**Next of Kin details:**

Name and address:

Contact email: .....

Contact phone: .....

Has the individual given consent for the above person to be contacted?            **Y**        **N**

Relation to individual: .....

Is next of kin also nearest relative?

**Additional information:**

Physical health conditions & supporting info where applicable:

Does the individual attend any regular hospital appointments?

Does the individual have specialist care plans? (eg. for diabetes or epilepsy)

**Y N**

If yes, please attach copies

Additional information; (Include any further relevant information & details of preferred service for consideration, if known)

Does the individual currently have any planned appointments?

**Risk Consideration:**

Risk Factor	Historical Risk	Further Information
Self-Harm		
Suicide		
Violence and aggression - self		
Violence and aggression - peers/staff		
Sexual Risk to Others		
Arson		
Vulnerability		
Safeguarding		
Drug Misuse		
Alcohol Misuse		
Absconding		
Non-compliance with medication		
Absconding on discharge		

**Internal Use Only**

BRM: ..... Rationale for FT/SFT?

Assessment type:

Standard FT SFT