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

Please complete in full and return to the Referral & Assessment Unit: referrals@stpatricks.ie
St. Patrick's University Hospital, P.O. Box 136, James's St., Dublin, D08 K7YW
Tel: 01 249 3635

All referrals to our Adolescent Services are reviewed by our Adolescent 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 Adolescent Inpatient Admission: ☐
Assessment for Adolescent Outpatient services ☐

All suitable 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 the Dean Outpatient clinics and psychotherapies.*

YOUNG PERSON DETAILS:

Name: _____

Address: _____

_____

Date of Birth: / / **Telephone:** **Gender:** F / M

PARENT CONTACT DETAILS

Mothers name: _____

Telephone:_____

Email Address: _____

Fathers name: _____

Telephone: _____

Email Address: _____

Address (if different from above) _____

_____

LEGAL GUARDIANSHIP: **Sole** ☐ **Joint** ☐ **Care order** ☐

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 child or adult 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):

History of Deliberate self-harm or suicidal ideation?

Risk to others: ☐ YES ☐ NO (If Yes, please provide detail):

Past Psychiatry History *(Include admissions if applicable)*:

Past Medical & Surgical History:

Family & Social History:

History of Addiction and Forensics:

History of violence and aggression:

Medications (past or current):

If the referral is in relation to a possible eating disorder, please provide current BMI and a copy of any recent bloods or ECG

Additional Information:

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 and will accept back care if they are admitted to Willow Grove Adolescent unit.

I have consent from _____(parent(s)/guardian(s) for a member of St Patricks Mental Health Services adolescent referral team to make initial phone contact with one or both parents/guardians of the young person if required to conduct via telephone a prompt assessment of needs to help determine suitability for SPMHS.

Signed: _____ Date: _____

How did you hear about our service: Media ☐ Literature ☐ Other: