Referral Information
Call 0808 164 4450
Email 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	Included 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	Included 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: ....

Continued >>

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

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?

Continued >>

Additional information:

Physical health conditions & supporting info where applicable:

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

Y **N**

If yes, please attach copies

Does the individual currently have any planned appointments?

Does the individual attend any regular hospital appointments?

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

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