G.P Referral to the Dean Clinics for Psychiatric Assessment

Please complete in full and return to:

The Dean Clinic Referrals, St Patrick's University Hospital, James's Street, Dublin 8.
Ph: 01-2493535 Fax: 01- 2493609
For more information visit: www.stpatrickshosp.ie

Patient's Contact Details:	**Referrer's Contact Details:**
Name:	**Name:**
Address:	**Address:**
Date of Birth:	**Fax No:**
Telephone No:	**Telephone No:**
Gender:	**Email:**

Reason for Referral: ____

____

____

____

Date of Onset of Present Complaint: ____

Has this person seen you or another clinician in relation to this or another Mental Health Condition previously? YES NO DON'T KNOW

Risk to Self: ____

Risk to Others: ____

Past Psychiatric Hx (N.B **Please include copies of correspondence**)**:** ____

____

____

____

Past Medical & Surgical Hx: ____

____

Family/Social Hx: ____

____

Medications: ____

____

Hx of Addiction or Forensics: ____

____

____

Blood Results required for day of assessment
FB**C:**
TFT's:
Renal & LFT's:

INSURANCE DETAILS:

Health Insurance: Yes/No
Health Insurance Name **(please tick relevant insurer):**

VHI ☐ **QUINN** ☐
AVIVA ☐ **OTHER (Please state)** ________________

Policy Number: ____________________________

I understand that I retain clinical responsibility for this patient until they are seen at the Dean Clinics. Both Referrer and Patient will receive confirmation of appointment.	
Signed:	**Dated:**

How did you hear about our service ? Media ☐ Literature ☐ Other (Please state): ________________

FOR OFFICIAL USE BY ST PATRICK'S UNIVERSITY HOSPITAL
REFERRAL OUTCOME Risk Assessment: HIGH MEDIUM LOW Comments: ____ ____