

REFERRAL FORM

Inpatient Admission Referral

Willow Grove Adolescent Mental Health Services



Please Complete **All** Sections and Return the Referral Form by Post / Fax

To the Adolescent Mental Health Services Team @

- The Dean Clinic, Old Lucan Road, Co Dublin Tel: 016515212 Fax: 016217978
- Willow Grove Adolescent Unit, St Patricks University Hospital, James's Street, Dublin 8
Tel: 01 2493687 / 01 2493690 Fax: 01 2493580

Young Person's Details

FULL NAME: (please print)		
MALE/FEMALE:	DATE OF BIRTH: (dd/mm/yy)	CURRENT AGE:
MARITAL STATUS:	ETHNIC GROUP:	1 ST LANGUAGE
PATIENTS ADDRESS:		
SCHOOL Is the young person currently attending school? Yes / No		SCHOOL YEAR
DOES THE YOUNG PERSON HAVE A RECOGNISED DISABILITY?		

Referrer's Details

TODAYS DATE: (dd/mm/yy)	Contact Address:
Name of Referrer:	
Contact Phone Number:	
Contact Fax Number:	
Email Address:	

Parent's / Guardian's Details

NAME:	CONTACT ADDRESS:
CONTACT PHONE NUMBER:	
NAME:	CONTACT ADDRESS:
CONTACT PHONE NUMBER:	

Reason for Referral

If Needed Please Include Additional Information On Separate Pages

RISK TO SELF:

RISK TO OTHERS:

PAST PSYCHIATRIC HISTORY(PLEASE INCLUDE ALL CORESPONDENCE)

PAST MEDICAL HISTORY: Include Any Known Allergies - Has a medical examination recently been carried out? - Date & Outcome?

FAMILY / SOCIAL HISTORY:

MEDICATIONS:

FORENSIC HISTORY / SUBSTANCE MISUSE:

Any Referral's to (past / present) <i>Please Tick</i>		Current Services Involved <i>Please Tick</i>	
Social Services? / In Care?		Social Work? / In Care?	
Other mental health services?		Paediatrician?	
Other psychology services?		Community Psychology?	
This service previously?		Speech and Language Therapy?	
Any Other?		Autism Services?	
		Any Other?	

Has Parental / Guardian consent been given? <i>Please Tick</i>			
Both Parents/Guardians		Neither	
One Parent (Father)		One Parent (Mother)	

*** PLEASE NOTE THAT THERE IS AN ATTENDANCE FEE AT THE ASSESSMENT CLINICS**

Health Insurance? YES / NO	Name of Insurer:	Policy Number:
<i>"I understand that I retain clinical responsibility for this patient until they are seen at the assessment clinics" Both Referrer and Patient will receive confirmation of the appointment.</i>		
Signed:		
Name (Block Letters)		Date:

BRIEF RISK INDICATOR CHECKLIST

Clients Name: _____

D.O.B. ___/___/___

Assessor: _____

RISK BEHAVIOUR IN PAST YEAR

- Self Harm
- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| Act with suicidal intent (e.g. overdose) | <input type="checkbox"/> | <input type="checkbox"/> |
| Suicidal talk | <input type="checkbox"/> | <input type="checkbox"/> |
| Self-injury (e.g. cutting) | <input type="checkbox"/> | <input type="checkbox"/> |
| Other method of self-harm (e.g. head banging) | <input type="checkbox"/> | <input type="checkbox"/> |

- Self-Neglect
- | | | |
|---|--------------------------|--------------------------|
| Self-neglect (e.g. nutrition, hygiene, health, finance) | <input type="checkbox"/> | <input type="checkbox"/> |
| Refusal of services | <input type="checkbox"/> | <input type="checkbox"/> |
| Risk of losing essential services | <input type="checkbox"/> | <input type="checkbox"/> |
| Risk of eviction | <input type="checkbox"/> | <input type="checkbox"/> |
| Risk from environment | <input type="checkbox"/> | <input type="checkbox"/> |
| Discontinuation of medication | <input type="checkbox"/> | <input type="checkbox"/> |

- Harm From Others
- | | | |
|---|--------------------------|--------------------------|
| Risk of Neglect | <input type="checkbox"/> | <input type="checkbox"/> |
| Risk of physical abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| Risk of sexual abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| Risk of financial abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| Risk of emotional/psychological physical abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| Risk of over medication | <input type="checkbox"/> | <input type="checkbox"/> |
| Risk of unlawful restrictions (e.g. locks on doors) | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical restraints, etc). | <input type="checkbox"/> | <input type="checkbox"/> |

- Harm to Others
- | | | |
|--|--------------------------|--------------------------|
| Sexual Assault (including touching/exposure) | <input type="checkbox"/> | <input type="checkbox"/> |
| Risk to child | <input type="checkbox"/> | <input type="checkbox"/> |
| Violence to family | <input type="checkbox"/> | <input type="checkbox"/> |
| Violence to staff | <input type="checkbox"/> | <input type="checkbox"/> |
| Violence to other patients | <input type="checkbox"/> | <input type="checkbox"/> |
| Violence to general public | <input type="checkbox"/> | <input type="checkbox"/> |
| Arson | <input type="checkbox"/> | <input type="checkbox"/> |
| Exploitation of others (e.g. financial, emotional) | <input type="checkbox"/> | <input type="checkbox"/> |

- Other
- | | | |
|---|--------------------------|--------------------------|
| Substance abuse (e.g. alcohol/drug abuse) | <input type="checkbox"/> | <input type="checkbox"/> |
| Incidents involving the police | <input type="checkbox"/> | <input type="checkbox"/> |
| Absconding | <input type="checkbox"/> | <input type="checkbox"/> |
| Accidental harm at home (e.g. falling, careless Smoking, discriminating hot/cold) | <input type="checkbox"/> | <input type="checkbox"/> |
| Accidental harm outside the home (e.g. wandering) | <input type="checkbox"/> | <input type="checkbox"/> |
| Dealing with hazards | <input type="checkbox"/> | <input type="checkbox"/> |
| Driving | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please specify) | <input type="checkbox"/> | <input type="checkbox"/> |

- AWARENESS OF RISK
- | | | |
|------------------------------------|--------------------------|--------------------------|
| Is the person aware of the risks | <input type="checkbox"/> | <input type="checkbox"/> |
| Would they be able to summon help? | <input type="checkbox"/> | <input type="checkbox"/> |
| TCP Level _____ | | |

RISK ASSESSMENT – HISTORY

- History of suicide attempts (ever)
- | | |
|-----------------|--------------------------|
| One | <input type="checkbox"/> |
| Two | <input type="checkbox"/> |
| Three | <input type="checkbox"/> |
| More than three | <input type="checkbox"/> |
| Not Known | |

- History of Severe Neglect (ever)
- | | |
|-----------|--------------------------|
| No | <input type="checkbox"/> |
| Yes | <input type="checkbox"/> |
| Not Known | <input type="checkbox"/> |

- History of Harm to Others (ever)
- | | |
|-----------|--------------------------|
| No | <input type="checkbox"/> |
| Yes | <input type="checkbox"/> |
| Not Known | <input type="checkbox"/> |

- History of Violence (ever)
- | | |
|------------------------|--------------------------|
| None | <input type="checkbox"/> |
| One incident | <input type="checkbox"/> |
| More than one incident | <input type="checkbox"/> |
| Not known | <input type="checkbox"/> |

- Most Serious Harm Caused
- | | |
|----------------|--------------------------|
| None | <input type="checkbox"/> |
| Minor Injury | <input type="checkbox"/> |
| Serious Injury | <input type="checkbox"/> |
| Fatality | <input type="checkbox"/> |
| Not Known | <input type="checkbox"/> |

- History of Risk to Child (ever)
- | | |
|-----------|--------------------------|
| No | <input type="checkbox"/> |
| Yes | <input type="checkbox"/> |
| Not Known | <input type="checkbox"/> |

- History of Containment (ever)
- | | |
|-----------|--------------------------|
| No | <input type="checkbox"/> |
| Yes | <input type="checkbox"/> |
| Not Known | <input type="checkbox"/> |

- History of Unplanned Cessation of Contact with Services
- | | |
|-----|--------------------------|
| Yes | <input type="checkbox"/> |
|-----|--------------------------|

- Forensic History (ever)
- | | |
|-----------|--------------------------|
| No | <input type="checkbox"/> |
| Yes | <input type="checkbox"/> |
| Not Known | <input type="checkbox"/> |

CURRENT MENTAL STATE

Are there any active symptoms which indicate an increased risk harm to self or others? Yes No

Diagnosis _____

Information obtained From: Client Case Notes Relative/Carer Professional Other

Summary - Nature of Risk: _____

Action Taken : Completion of Full Risk Assessment Discussed with Team Discussed with Other e.g. supervisor

Signature of Assessor : _____

Date ___/___/___