**Urgent Mental Health Helpline - Urgent Referral Form for Professionals**

For routine referrals to Community Mental Health Services, please contact the appropriate locality CMHT / CMHSOP directly.

For urgent referrals, please complete this form IN FULL and send to

**Kmpt.urgentreferrals@nhs.net**

If insufficient information is provided to make a clinical decision then the referral will be returned.

***Please inform the patient that the Urgent Mental Health Helpline is a telephone triage service, it does not offer face to face appointments. Once the referral has been accepted the service will attempt 2 telephone contacts between the hours of 07:30hrs and 22:00hrs, 7 days a week. If the patient does not respond the referral will be closed. Please emphasise the importance of taking the call or responding to any messages left.***

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| **Please tick all symptoms or behaviours that have been present in the last 2 weeks** | | | ☑ |
| Anxiety or depression without suicidal ideas |  | Cooperative, communicative and compliant with instructions |  |
| Substance misuse |  | Irritable without aggression |  |
| Suicidal thoughts with no plan |  | Financial / social / accommodation / relationship problems |  |
| Absence of insight to current difficulties |  | Agitated, restless or distressed |  |
| Mood Disturbance (severe symptoms of depression, anxiety or elated mood) |  | Intrusive or bizarre behaviour |  |
| Psychotic Symptoms (hallucinations, delusions, paranoid ideas) |  | Withdrawn |  |
| Suicidal plan and/or access to means |  | Extreme agitation or restlessness |  |
| Thoughts to Self-Harm |  | Verbal aggression |  |
| Thoughts to harm others |  | Severe confusion |  |
| Overdose |  | Aggression or violence towards others |  |
| Suicide Attempt |  | Possession of a weapon |  |
| Deliberate Self-Harm |  | Destruction of property |  |

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| **DATE OF REFERRAL:** | | | |
| **DEMOGRAPHICS** (PLEASE CHECK DETAILS ARE CORRECT WITH PATIENT) | | | |
| **NHS Number** |  | **Date of Birth** |  |
| **Last Name** |  | **First Name** |  |
| **Gender** | Male Female | **Pregnant?** | Yes  No  N/A |
| **Current address include full Postcode** |  | | |
| **Home Number** |  | **Mobile Number** |  |
| **Can messages be left on these numbers?** | | Home Mobile | |
| **Email address** |  | | |
| **GP Name** |  | **GP Surgery** |  |
| **Ethnicity** |  | **Religion** |  |
| **Nationality** |  | **Disability** |  |
| **Preferred Language** |  | **Interpreter?** | Yes  No |
| **REFERRER INFORMATION** | | | |
| **Referrer Name** |  | **Designation** |  |
| **Referrer address**  **include full Postcode** |  | | |
| **Phone number** |  | **Email** |  |
| **Is Patient aware of Referral?** | **Yes**  **No** | **If No, please state reason** |  |
| **safeguarding** | | | |
| **Are there any children or vulnerable adults living at the same address?** | | **Yes**  **No** | |
| **Child safeguarding concerns?** | **Yes**  **No** | **Adult safeguarding concerns?** | **Yes**  **No** |
| **Please specify the nature of the safeguarding concerns** | |  | |
| **Please list the names and dates of birth of any children of the patient or living at the same address** | |  | |
| **Please list any other professionals or agencies currently involved** | |  | |
| **REASON FOR REFERRAL** | | | |
| **Current Situation**  *Please include summary of current symptoms, mental state, known risks, alcohol or substance misuse and current mental health medication. Please also include details of what primary care interventions have been initiated prior to referral to secondary care.* | | | |
| **Previous History**  *Please include brief summary of any previous mental health history, previous mental health medications or any talking therapies that have been utilised as per NICE guidelines.* | | | |