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| **Forensic Community Team**  **(North East and Cumbria)**  **Referral Form** |

A Complete



**Referral Criteria**

Before completing the referral, please ensure that the following criteria are met.

* Patient is aged 18 and over
* Patient has a **primary** diagnosis of mental illness
* Patient has a named Care Co-ordinator
* Patient is open to secondary mental health services
* Patient is demonstrating significant actual or potential risks to others
* Patient is in the community or preparing for discharge

**Please ensure that all check boxes above are completed. If there are any omissions we cannot accept the referral.**

In the case of unchecked boxes, please contact us via [ForensicCommunityTeam@cntw.nhs.uk](mailto:ForensicCommunityTeam@cntw.nhs.uk) to discuss the case.

**Guidance notes for completing Referral Form**

The Forensic Community Team (FCT) requires specific information in order to proceed with a referral.

Please ensure that all sections are completed. Ensure that the form is typed, not handwritten.

Do not state “refer to RiO/PARIS”.

**An uncompleted document will result in being sent back to the referrer.**

**On Completion**

Completed forms should be emailed to: [ForensicCommunityReferrals@cntw.nhs.uk](mailto:ForensicCommunityReferrals@cntw.nhs.uk)

**Queries**

For any queries or assistance completing the form, please contact:

Jackie Irving (Medical Secretary) on 0191 2467267 [jackie.irving@cntw.nhs.uk](mailto:jackie.irving@cntw.nhs.uk)

Jennifer Thompson (Team Secretary) on 0191 2467273 [jennifer.thompson2@cntw.nhs.uk](mailto:jennifer.thompson2@cntw.nhs.uk)

If you have queries regarding the suitability of referral, please contact

Mark Scott (Team Manager)

Teresa Campbell (Clinical Lead) on [ForensicCommunityTeam@cntw.nhs.uk](mailto:ForensicCommunityTeam@cntw.nhs.uk)

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| **Name** |  | | | | **DoB (and age)** |  | | | |
| **RiO Number** |  | | | | **PARIS No** |  | | | |
| **NHS Number** |  | | | | **MHA Status** |  | | | |
| **Gender** |  | | | | **Ethnic Origin** |  | | | |
| **First Language** |  | | | | **Is an Interpreter required?** | **Yes** |  | **No** |  |
| **Home Address** |  | | | | | | | | |
| **Current Location** |  | | | | | | | | |
| **Care Co-ordinator** |  | | | | **Consultant Psychiatrist(s)** |  | | | |
| **Current CTT**  **(if applicable)** |  | | | | | | | | |
| **GP** |  | | | | | | | | |
| **GP Address & Contact No.** |  | | | | | | | | |
| **Local Authority** |  | | | | **Who is allocated from the LA?** |  | | | |
| **Other Key Clinicians and Teams Involved** |  | | | | | | | | |
| **Is the patient known to MAPPA/MARAC?** | **Yes** |  | **No** |  | **If yes, what Level?** |  | | | |
| **Referrer(s)** |  | | | | | | | | |
| **Referrer Address & Contact Details** |  | | | | | | | | |
| **Is the patient aware of the referral?** | **Yes** |  | **No** |  | **If No, why?** |  | | | |
| **Date Completed** |  | | | | | | | | |

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| **Reason for Referral** | | | |
|  | Assessment | Assessment of the patient to support risk management and treatment | |
|  | Risk Advice and Scaffolding | Advice and support for the team and/or Care Co-ordinator – which may include attendance at professionals’ meetings. This could also include specialist advice on risk assessment and management completed by the FCT and Care Co-ordinator.  *Please provide details of any professionals’ meetings or discharge planning meetings that you would like the FCT to attend.*  *Please note: where a specific piece of work is required, significant background information will be required from the referring team.* | |
|  | Forensic Liaison Clinic (FLC) | FLC is an opportunity for the current care team to discuss the case with key individuals from the FCT. | |
|  | In-Reach | In-reach work in anticipation of Care Co-ordination.  *Please note: this is only for those patients coming though the secure in-patient pathway and forensic supported accommodation (Westbridge)* | |
| **Forensic Services Only** | | | |
| **Has the patient been referred to the SCFT? What was the outcome? Why were they declined?** | | | |
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| **Date Referred to SCFT** | | |  |
| **Estimated Discharge Date?** | | |  |

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| **Diagnosis** |
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| **Risk Summary** | | | |
| **Risk (check the box if it applies and add narrative below)** | | | |
| Offending behaviour |  | Stalking |  |
| Sexual offending |  | Substance Misuse |  |
| Domestic Violence |  | Safeguarding Adult issues |  |
| Harm to others |  | Safeguarding Children issues |  |
| Fire setting |  | Child protection issues |  |
| Self-harm |  | Current or past neglect |  |
| **Previous Criminal/Offending History**  ***(include violent behaviours/ideas; severity; location; circumstances; precipitants etc)*** | | | |
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| **Current Risk Assessment and Management Plan** | | | |
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| **What is the particular behaviour of concern currently?** | | | |
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| **If you are requesting a FLC are there any areas you would like us to focus on?**  **What do you hope we can achieve during the FLC?** | | | |
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| **Case Summary** |
| **Background History**  ***(Family/personal/developmental/social history)*** |
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| **Psychiatric History**  ***(Including presenting features, diagnoses, treatments, outcome for each episode)*** |
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| **Drug and Alcohol History** |
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| **Medical/ Physical Health History and Needs** |
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| **Current Medication** |
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| **Recent Mental State Examination** |
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| **Previous involvement with Forensic Services** |
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| **Previous history in relation to engagement with Services** |
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| **Any further information that may be helpful to the Forensic Community Team?** |
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