**Northumberland Community Treatment Team (CTT)**

**Referral form**

Northumberland Community Treatment Team (CTT) is a non-urgent service that handles referrals daily during business hours.

For any assistance in completing this form, please contact 01670 844758

**PLEASE SEND THIS REFERRAL TO:** **NlandWAACTTReferrals@cntw.nhs.uk**

**IF YOU REQUIRE AN URGENT PSYCHIATRIC REFERRAL, then PLEASE CALL 03031231146 for advice and support. In an emergency, please dial 999 for assistance**

<Today's date>

For referrals to be processed as effectively as possible, please try to provide as much detail as you can in the following questions.

**It may be that we can refer patients onto a more appropriate service (this could be CNTW or an external service) if you gain their consent for us to do this. Please indicate by ticking the box that the patient referred has agreed to this:**

**I confirm that the patient gives consent to this referral and is aware of the potential for onward referral if deemed more suitable.**

**Is the referral based on remote contact or face to face:**

<Patient Name>

<Date of birth>

<Gender>

<Patient Address>

<Patient Contact Details>

**Referrer Name and Role, if not usual GP**

GP Name and Surgery

<GP Name>

<GP Details>

**Is this person presenting for the first time with this condition or is this an ongoing concern.**

 New Presentation

 Ongoing Issues, managed in practice

 Ongoing Issues, Known to Mental Health Services

**Please provide a brief description of why you are referring to the service:**

**Current Difficulties:** *(Including current signs and symptoms, duration/impact. If suspected Eating Disorder please provide Current height, weight, BMI and any historic BMI).*

**Risk to self/others:** *(safeguarding issues, neglect, forensic history, probation involvement)*

**Current level of support*:*** *(Social Care, Probation, Addiction Services, Physical Health Services)*

**Drug and Alcohol Use*:*** *(Past/present, impact on mental health and risk)*

**Expectation of Service User:** *(goals for treatment)*

**Any other relevant referrals, including any other mental health services involved?**

**Is the person being referred aware and consenting to this referral?**

**Current Medications**

<Medication(table)>

Past Medical History

<Problems(table)>

<Problems(table)>

Able to communicate in English?

Yes

No

If an interpreter is required, please specify language

Mobility issues

Yes

No

Ex British Armed Forces?

Yes

No

Any other relevant information that you wish to add?

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**April 2024**

**Review: April 2025**