

**REFERRAL FORM**

Complex Mental Health Service

**Referrer**

Name

|  |  |  |  |
| --- | --- | --- | --- |
| Referred by: |  | Date of referral: |  |
|  |  |  |  |
| Telephone: |  | Email: |  |
|  |  |  |  |
| Organisation: |  | Relationship: |  |
|  |  |  |  |

**Service User Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | D.O.B: |  |
|  |  |
| Address: |  |
|  |  |
| Postcode: |  |
|  |  |  |  |
| Tel Landline: |  | Tel Mobile: |  |

**Diagnosis / Mental Health / Physical conditions**

(Please provide as much information as possible. Include any support in place, restrictions, ADL skills, medication and CPA Level)

|  |
| --- |
|  |

|  |
| --- |
| **MHA SECTION / CTO / Injunction / Probation / MAPPA / SOR/Other** |
|  |

|  |
| --- |
| **Incidents in the last 6 months**  |
|  |
| **Additional Information**(Please include any additional information i.e. desired discharge date) |
|  |

**Office use:**

|  |  |
| --- | --- |
|  |  |
| Date of assessment booked: |  |
|  |  |
| Notes: |  |
|  |  |

**Eligibility Criteria:**

* Male aged 18-65
* Background information if available e.g. CPA Report, OT Report, etc.
* Service User is prepared to engage with support services provided

**Making a referral:**

We accept individuals with a primary diagnosis of severe and enduring mental illness, with offending history, who may have complex needs such as Schizophrenia, Personality Disorder, Mild Learning Disability and who may have been treated in a secure psychiatric hospital, residential care homes, prison service and have a history of challenging behaviours.

**Send completed form to:**

Email: referral@teessidepersonnel.co.uk

**Enquiries:**

Phone: 07526286963

Email: fungai@teessidepersonnel.co.uk