**Forensic Community Mental Health Team Referral**

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| Date of Referral: |  |
| Referrer: | Designation: |
| Has the referral been discussed with the patient’s consultant/RC: YES / NOIs the consultant/RC in agreement with the referral? : YES / NO |
| Address: |
| Tel No: |
| E-mail: |
| Signature: |

**Patient details**

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| Name of Patient: |  |
| Previous names / Aliases: |  |
| Date of Birth:Alias Birth Dates: |  |
| Address:(last known) |  |
| Name and address of GP: |  |
| Local CCG/PCART/CTPLD: |  |
| NHS Number: |  |
| Date of first contact made with mental health services: |  |
| Present location of patient: |  |
| Mental Health Act Status:Date section commenced:Last MHRT/Managers’:Next MHRT/Managers’:Date of next CPA Review: |  |
| MAPPA Level/Category: |  |
| Details of any criminal charges (actual or likely):Court dates: |  |
| Interpreter Required:  | YES / NO |
| Have they or a family member, served in the Armed Forces?  | YES / NO |
| Marital Status: | Ethnicity: | Religion: |

**Referral**

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| --- | --- |
| **Question 1**Is this referral for:**Level 4** – Full CPA/RC responsibility by the Forensic Community Mental Health Team,**Level 3** – Joint working with mental health services with the Forensic Community Mental Health Team taking the lead role (typically a period of handover),**Level 2** – A single consultation, assessment or joint working as above but with non-forensic mental health services taking the lead role (typically short term support/consultation),**Level 1** – by tracking individuals who are in secure or specialist hospital placements or prisons and will require FCMHT services on their return to Derbyshire. |  |
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| **Question 2**Are you aware of any previous forensic assessments? If so, when and by whom? |
| **Question 3**Please provide a brief summary of the case. (Full details must be provided in the form of a typed summary including full psychiatric history, known forensic history, current diagnosis and treatment plan; failure to attach such a summary is likely to result in a delay in processing the referral). |
| **Question 4**What are the questions to which you require an answer?For Risk Assessments requests, please specify whether this is a general assessment or refers to a specific risk (e.g. expressed homicidal intent towards a particular individual or a group, such as children) |

**Referral Form Guidelines**

**Information Required**

*This form should be accompanied by:*

1. Full psychiatric history (including history of offending not resulting in charges).
2. Current Care Plan.
3. Up to date risk assessment.

The referrer must also include the following information:

* Purpose and expectations of the referral (i.e. consultancy, joint working, or full CPA transfer). The referral should clearly indicate the reason why you wish us to assess the patient by stating what question or questions you wish us to answer.
* Available details of the specific or general risks or concerns to be assessed.

**Where to send this form to**

Please send the referral to:

Forensic Community Mental Health Team

Kingsway West House

Kingsway Hospital

Derby

DE22 3LZ

Tel: 01332 623793

Team email address: dhcft.forensiccmht@nhs.net

Referrals will be accepted via email following a telephone call to clarify the appropriate recipient

**What happens next?**

All referrals will be screened by a senior clinician within the team and acknowledged within 2 working days; requests for further information will then be made if required.

The referral will be discussed at the weekly FCMHT meeting and allocated to the appropriate team member within 10 working days; the referrer will be informed of the allocated worker. Where immediate action is indicated, the team will liaise with the referrer and advise of the appropriate course of action verbally, following this up in writing as soon as practicable.

The patient will usually be seen within 30 working days and the referrer updated within 5 working days after the initial visit. A full report will be sent to the referrer, usually within 40 working days.