VINEYARD CARE

REFFERAL FORM

All submissions to **refer@vineyard-care.co.uk**

This form is to be completed by professional referrers only (i.e. Doctor, Registered Mental Health Nurse, Social Worker, Occupational Therapist, Care Services Managers).
We recommend that the referrer engages patients views wherever possible.

PERSONAL DATA (PATIENT)

First Name:

Middle Name:

Surname:

Date of Birth: D D M M Y Y

Gender: Male Female Other Specify

Marital Status: Single Married Divorce Widow/er Other

Current Inpatient: N/A Rehabilitation Acute ward PICU LSU

Community setting (Current/Recent): Alone (Flat/House) Shared with others 1 2 3+

National Insurance No.:

Telephone No:

First Language:

Interpreter required Y N

NEXT OF KIN DETAILS

Full Name:

Relationship to Patient:

Full Address:

Postcode:

City/County:

Email Address:

Telephone No:

COMMUNITY MENTAL HEALTH PROFESSIONAL /CARE COORDINATOR

Name of Consultant/ Social Worker	
Office Address	
Telephone No:	
Email Address:	

MENTAL HEALTH MULTIAXIAL

Axis I (Active Mental Disorder/s):	
Axis II (Personality Disorders/ Intellectual disabilities):	
Axis III (Physical Health conditions)	
Axis IV (Psychosocial/ Environmental stressors)	
Axis V (Global Assessment of Functioning) 0 to 100	

PSYCHIATRIC SIGNS (Part of our Enhanced Psychosis Pathway)				
	Recent Episode of illness	**Past Episode/s of illness**	**Never**	**Further Details (Date/Year)**
Command Auditory Hallucinations				
Other Auditory Hallucinations				
Persecutory delusion				
Passivity phenomenon				
Weapon carrying associated with Psychosis				
Assault of others associated with Psychosis				
Psychomotor agitation				
Impulsivity				
Hopelessness/ Helplessness				

PERSONAL CARE NEEDS (See Rating Guide)

	High Support	Medium Support	Low Support	No Support
A - Personal Hygiene/Bathing:				
B - Dietary needs/Cooking				
C - Medication Compliance:				
D - Meaningful routines/Wellness:				

HOUSING SUPPORT NEEDS (See Rating Guide)

	High Support	Medium Support	Low Support	No Support
A – Budget/ Finance:				
B – Shopping:				
C – Utility Bills:				
D – Maintaining Tenancy:				

COMMUNITY ACCESS NEEDS (See Rating Guide)

	High Support	Medium Support	Low Support	No Support
A – Transport/Road awareness:				
B – Vulnerability to Exploitation:				
C – Social Skills/Anxiety:				
D – Group Activities/Appointments:				

OTHER AREAS OF BASIC SUPPORT (Tick)			
	Reading/Writing		Other
	Number Skills		None applicable
	Communication Language		

Additional Comments:

_____

_____

_____

Details of any Outstanding Debts:

_____

_____

Subject to 117/Aftercare : YES NO

If Yes, Last Section 3 Discharge: Current Admission Date: _____

Requirement for CTO Identified: YES NO

Requirement for Appointeeship identified: YES NO

RISK HISTORY (Risk from Others)				
	Current Less than 12 months	**Past** 12 months or more	**Never**	**Further details**
Sexual exploitation				
Financial exploitation				
Domestic abuse				
Physical Harm/ Assault				
Theft/Scams				
Bullying/Control				
Racially motivated incidents				
Emotional abuse				
Other risks (Specify)				

RISK HISTORY (Risk to Health and Safety)

	Current Less than 12 months	**Past** 12 months or more	**Never**	**Further Details**
Alcohol Misuse/Addiction				
Illegal Drug Use/Addiction				
Legal Highs				
Poor Healthcare				
Self Neglect				
Suicidal Thoughts (No attempts)				
Deliberately Self Harming				
Suicide Attempt				

RISK HISTORY (Risk to Others)				
	Current Less than 12 months	**Past** 12 months or more	**Never**	**History of Caution/ Convictions**
Public Disorder offences				
Sexual Offences				
Sexual Offences against children				
Arson				
Firearms/ Weapon carrying				
Theft or burglary attempt				
Criminal Damage				
Threatening or Verbal Aggression				
Racially motivated incidents				
Physical violence/ assault/ABH/GBH				
Aggression directed to staff in the course of care delivery				
Murder or manslaughter				

HIGHEST LEVEL OF INPATIENT OBSERVATION AND/OR COMMUNITY SUPPORT (Within the last 4 weeks)

Community Support (If applicable)

Support Type: Personal ☐ Housing/Tenancy ☐

Hours of Day Support 1 -2 ☐ 3-5 ☐ 6+ ☐

Waking Night: Yes ☐ No ☐ Not Applicable ☐

Inpatient Observation (If applicable)

Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4 ☐

Note: Level 1= Hourly, Level 2= 5 to 30 minutes, Level 3= Eye sight, Level 4= Arms Length

DETAILS OF THE REFERRER

NAME:		ROLE:	
ADDRESS:		TELEPHONE:	

The information entered is of highest accuracy and attention, to the best of my knowledge.

SIGNATURE:	
DATE:	

Please submit completed form to: refer@vineyardcare.co.uk

FOR SERVICE USE ONLY

REFERRAL ACCEPTANCE OR REJECTION

What is primary support need?

	YES	NO
Mental Health		
Substance Misuse		
Physical		
Housing		
Accept referral and proceed to assessment?		

We exclude referrals whose primary reasons are Housing or Physical health.

Explanation of reason, if rejected: