

**Mental Health Act 1983 Referral Form B V2**

**This form should only be completed for a Community Treatment Order, Guardianship or re-grade for individuals already detained under the Act. All other referral requests should be completed on Form A.**

|  |
| --- |
| **Details of the individual being referred** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Individuals name:** |  | **Individuals home address:** |  |
| **Preferred name:** |  | **Date of birth:** |  |
| **Gender at birth:** |  | **Individuals contact number:** |  |
| **Gender individual identifies as:** |  | **Individuals current location:** |  |
| **NHS Number:** |  | **Is the individual aware of the referral?** |  |
| **Ethnicity:** |  | **LAS Number:**  **(If known)** |  |
| **Preferred language:** |  | **Does the individual need an interpreter/signer?** |  |

|  |
| --- |
| **Referrer details** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer name:** |  | **Referrer address:** |  |
| **Referrer job title:** |  | **Referrer contact number:** |  |
| **Referrer email address:** |  | **How long has the referrer known the individual:** |  |

|  |
| --- |
| **Nearest Relative Information (If known)** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **NR address:** |  |
| **Relationship:** |  | **NR contact number:** |  |

**Please note, if the individual is known to mental health services, the referrer is required to send the latest copy of the GRIST and Crisis Plan.**

**If a request for a Guardianship application is being made, please ensure that the latest copy of the care plan and risk assessment are up to date and sent with this referral.**

|  |  |
| --- | --- |
| **Mental Health Services Involvement** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Team name:** |  | **Responsible clinician:** |  |
| **Named professional:** |  | **Team contact number:** |  |
| **Does the individual have a MH diagnosis (please state):** |  | **Does the individual have a drug/alcohol dependency? (If yes, provide brief details and confirm fit for an assessment:** |  |
| **Is the individual subject to s117?** |  | **LA and ICB (Integrated Care Board) with s117 responsibility:** |  |

|  |  |
| --- | --- |
| **Has the individual previously been admitted to a psychiatric hospital? (Please provide dates/brief history):** |  |

|  |
| --- |
| **Community Treatment Order Referral** |

|  |  |
| --- | --- |
| **CTO 1: For a new CTO, what are the proposed dates of the discharge planning meeting?** |  |
| **CTO 7: Renewal of CTO, when is the current CTO due to expire? Provide details of planned review with RC.** |  |
| **CTO 5: Revocation, where is the revocation form held? What is the purpose/reason for revocation?** |  |
| **Outline current circumstances leading to this request:** |  |

|  |
| --- |
| **Request for an assessment and re-grade under the MHA’83** |

|  |  |
| --- | --- |
| **What is the current status of the individual (i.e., informal or detained under the MHA’83):** |  |
| **What assessment and re-grade is requested (i.e., s2 due to expire, s5(2) in place, s4 in place), please state time of expiry:** |  |
| **When was the individual last reviewed by the Responsible Clinician (include name, date and time), what was the outcome/recommendation from this review:** |  |
| **Please provide details of which least restrictive options have been offered and implemented prior to this referral (i.e., HTT, Crisis Team, informal admission) and what the outcomes and dates of such interventions are:** |  |
| **Has a medical recommendation been completed? If so, please state date form completed, location of form and briefly explain why a multi-agency assessment was not initiated:** |  |
| **Outline any other current circumstances leading to this request for an assessment and re-grade:** |  |

|  |
| --- |
| **Request for a Guardianship Application** |

|  |  |
| --- | --- |
| **When was the individual last seen, by whom and what was the outcome of this visit:** |  |
| **When was the individual last reviewed by a medic (include name), what was the outcome/recommendation from this review:** |  |
| **What interventions have been put in place prior to this request for a Guardianship application:** |  |
| **Has suitable accommodation and funding been identified (please provide details):** |  |
| **Has access to community support, education and training been identified as appropriate (please provide details):** |  |
| **Are key professionals and organisations already involved and/or referred to? (Please provide details):** |  |
| **Does the individual have capacity regarding the Guardianship and if so, are they aware of the suggested plans? (Provide brief details):** |  |
| **Have the nearest relative and significant individuals been consulted with/in support:** |  |
| **Outline any other current circumstances leading to this request for a Guardianship application:** |  |

|  |
| --- |
| **Risk Management** |

|  |  |
| --- | --- |
| **What are the current and immediate risks to the individual:** |  |
| **What are the current and immediate risks to others:** |  |
| **Are there any significant risk history factors (i.e., violence/weapons)?** |  |
| **Is the individual vulnerable to other forms of risk (i.e., self-harm, self-neglect, exploitation by others):** |  |
| **Is a safeguarding referral required? If yes, has this been completed (please include date/time of referral):** |  |
| **Referring to the risk threshold matrix (pg 5), how would you rate the current level of risk (please state red, amber, or green).** |  |

|  |
| --- |
| **Consent and onward planning** |

|  |  |
| --- | --- |
| **Does the individual have capacity at this current time, has this been assessed and documented:** |  |
| **(If the individual has capacity) Has this request been discussed with the individual, if so, provide outcome of discussion, if not please state rationale:** |  |
| **Has a LAEP meeting been convened for people with ASD/LD, provide details:** |  |

|  |
| --- |
| **Referral completion details** |

|  |  |
| --- | --- |
| **Date and time referral completed:** |  |
| **Referrer, please sign name to confirm that the information contained in this report is accurate and up to date regarding the individual circumstances and individual referred:** |  |

**Please send the completed Referral Form to** [**amhpteam@worcestershire.gov.uk**](mailto:amhpteam@worcestershire.gov.uk)

**Telephone contact details: 01905 846877**

**Risk Threshold Matrix**

|  |  |
| --- | --- |
| **Referral category** | **Current presentation** |
| **Red: Immediate High Risk**  Significant Harm to self and or others.  Severe behavioural disorder with immediate threat of dangerous and violent behaviour. | Recent violent behaviour and/or history of violence when unwell (both to self and/or others)  Possession of weapon  Extreme agitation or restlessness  Bizarre/disoriented behaviour  Acutely psychotic or thought-disordered  Situational crisis, deliberate self-harm  Agitated/withdrawn  Receiving verbal commands to harm self or others that the person is unable to resist (command hallucinations)  Recent violent behaviour is unable to resist (command hallucinations)  Refusal of treatment/intervention/support |
| **Amber: Moderate Risk**  Possible risk of harm to self and / or others | Moderate agitation/restlessness  Verbally aggressive/threat of harm to others  Intrusive behaviour  Confused/unable to cooperate  Hallucinations/delusions/paranoia  Attempt at self-harm/threat of self-harm  Agitation/Restlessness  Ambivalent about treatment or not likely to wait for treatment  Suicidal ideation  Situational crisis  Hallucinations  Delusions  Paranoid ideas  Thought disordered  Bizarre/agitated behaviour  Severe symptoms of depression  Withdrawn/uncommunicative and/or anxiety  Elevated or irritable mood  Patient refusing intervention/support  Patient does not have capacity to make informed decision regarding their current care and treatment |
| **Green: Mild to Moderate Risk**    No immediate risk to self or others but making threats of self-harm  No acute distress or behavioural disturbance  Known patient with chronic symptoms | Mild tomoderate levels of agitation/restlessness  Irritable without aggression  Cooperative  Gives coherent history  Pre-existing mental health disorder  Symptoms of moderate anxiety ordepression  Moderate evidence of cognitive impairment  Ambivalent towards intervention/support  Cooperative/Communicative and able to engage in developing management plan  Able to discuss concerns/Compliant with instructions  Known patient with chronic psychotic symptoms  Pre-existing non-acute mental health disorder  Known patient with chronic unexplained somatic symptoms  Request for medication  Minor adverse effect of medication  Financial, social, accommodation, relationship difficulties |