Bloomfield Hospital Referral Form *Fax to 01 4951006*

Patient Contact Details	**Referrer Contact Details**
Name:	Name:
Address:	Address:
Date of Birth:	Fax:
Telephone:	Telephone:
Gender: Male ❑ Female ❑	Email:
Details of Patients Current Placement	**G.P Contact Details**
Organisation Name:	Name:
Contact Name:	Address:
Telephone:	Telephone:

Legal Status:			
Voluntary ❑ **Ward of Court** ❑			
Involuntary ❑			
Medical Card No:		**PPSN NO:**	
Funding-(Who will fund placement at Bloomfield Hospital)			
Type of funding:		Date Approved:	
Contact Name			
Please List Health Professionals involved in this Patient's care			
Name:	Designation:	Address:	Contact Number:

Next of Kin Contact Details:	**Main Contact Person (if different from Next of Kin)**
Name:	Name:
Address:	Address:
Telephone:	Telephone:

Clinical Details:
Reason for Referral:

Psychiatric History: (Include current mental state)
Please outline Voluntary/ Involuntary admissions
Family/Social History
Medical/Surgical History:
Medications:
(Attach Kardex)
Allergies:

Labs/recent imaging:

FBC's/U&E 's	☐	**Liver and Renal Function**	☐
Thyroid Function	☐		
Serum Calcium, Phosphate, Cholesterol, Lipids & Glucose	☐	**Serum B12 & Folate Levels**	☐
ECG	☐		
Neurology Report	☐		
Psychiatric Report	☐		
S.A.L.T	☐		
O.T assessment	☐		
Physiotherapy assessment	☐		
Risk Assessment(attached)	☐		
Nursing assessment	☐		

*****Please attach results of above*****

Please also complete a Brief Risk Assessment (attached)

Bloomfield HOSPITAL

BRIEF RISK ASSESSMENT

SURNAME:	Male:	Female:
FORENAMES:	Date of Birth:	
PATIENT'S ADDRESS:		

SOURCE OF INFORMATION		
❑ Other informants (family, friends)	❑ The consumer ❑ Previous clinical records	❑ Immediate carer (parent, spouse, child) ❑ Assessing clinician's knowledge of consumer's past behaviour/current clinical presentation
❑ Police/ambulance/other agencies	❑ Other (please specify) _____	

SUICIDALITY Static (historical) factors	Yes (1)	No (0)	Not Known	Dynamic (current) risk factor	Yes (2)	No (0)	Not Known
Previous attempt(s) on own life	☐	☐	☐	Expressing suicidal ideas	☐	☐	☐
Previous serious attempt	☐	☐	☐	Has plan/intent	☐	☐	☐
Family history of suicide	☐	☐	☐	Expresses high level of distress	☐	☐	☐
Major psychiatric diagnosis	☐	☐	☐	Hopelessness/perceived loss of coping or control over life	☐	☐	☐
Major physical disability/illness	☐	☐	☐	Recent significant life event	☐	☐	☐
Separated/Widowed/Divorced	☐	☐	☐	Reduced ability to control self	☐	☐	☐
Loss of job/retired	☐	☐	☐	Current misuse of drugs/alcohol	☐	☐	☐

PROTECTIVE FACTORS *(describe)* **:**

LEVEL OF SUICIDE RISK (total score): ☐ **LOW (<7)** ☐ **MODERATE (7-14)** ☐ **HIGH (>14)**

AGGRESSION/VIOLENCE Static (historical) factors	Yes (1)	No (0)	Not Known	Dynamic (current) risk factor	Yes (1)	No (0)	Not Known
Recent incidents of violence	☐	☐	☐	Expressing intent to harm others	☐	☐	☐
Previous use of weapons	☐	☐	☐	Access to available means	☐	☐	☐
Male	☐	☐	☐	Paranoid ideation about others	☐	☐	☐
Under 35 years old	☐	☐	☐	Violent command hallucinations	☐	☐	☐
Criminal history	☐	☐	☐	Anger, frustration or agitation	☐	☐	☐
Previous dangerous acts	☐	☐	☐	Preoccupation with violent ideas	☐	☐	☐
Childhood abuse	☐	☐	☐	Inappropriate sexual behaviour	☐	☐	☐
Role instability	☐	☐	☐	Reduced ability to control self	☐	☐	☐
History of drug/alcohol misuse	☐	☐	☐	Current misuse of drugs/alcohol	☐	☐	☐

PROTECTIVE FACTORS *(describe)* **:**

LEVEL OF VIOLENCE RISK (total score): ☐ **LOW (<7)** ☐ **MODERATE (7-14)** ☐ **HIGH (>14)**

OTHER RISKS IDENTIFIED (AND RISK FACTORS)

RISK MANAGEMENT ISSUES (please ensure alerts are noted here)

(To be completed by assessing clinician)

PRINT NAME: **DESIGNATION:** **SIGNATURE:** **DATE:**

(Where appropriate, management plan to be acknowledged by requesting medical practitioner)

PRINT NAME: **DESIGNATION:** **SIGNATURE:** **DATE:**

BRIEF RISK ASSESSMENT