

**Patient Contact Details**

Name: .....  
Address: .....  
.....  
Date of Birth: .....  
Telephone: .....  
Gender: Male  Female

**Referrer Contact Details**

Name: .....  
Address: .....  
.....  
Fax: .....  
Telephone: .....  
Email: .....

**Details of Patients Current Placement**

Organisation Name: .....  
Contact Name: .....  
.....  
Telephone: .....

**G.P Contact Details**

Name: .....  
Address: .....  
.....  
Telephone: .....

**Reason for Referral:**

16 week assessment:  .....  
Long-term placement:  .....  
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:**

Name: .....  
Address: .....  
.....  
Telephone: .....

**Main Contact Person:** (if different from Next of Kin)

Name: .....  
Address: .....  
.....  
Telephone: .....

**Clinical Details:**

**Summary of HD Diagnosis:**

.....

.....

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.....

.....

**Family/Social History:**

.....

.....

**Psychiatric History:** (Include current mental state)

Please outline Voluntary/Involuntary admissions. ....

.....

**Medical/Surgical History:**

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.....

**Medications:**

.....

.....

**Allergies:**

.....

.....

**Discharge Address:** (Following 16 week programme)

Address: .....

**Labs/recent imaging:**

- |  |  |
|--|--|
| <input type="checkbox"/> FBC's/U&E's               | <input type="checkbox"/> Liver and Renal Function                                |
| <input type="checkbox"/> Thyroid Function          | <input type="checkbox"/> Serum Calcium, Phosphate, Cholesterol, Lipids & Glucose |
| <input type="checkbox"/> Serum B12 & Folate Levels | <input type="checkbox"/> ECG   |
| <input type="checkbox"/> Neurology Report          | <input type="checkbox"/> Psychiatric Report                                      |
| <input type="checkbox"/> S.A.L.T                   | <input type="checkbox"/> O.T. assessment   |
| <input type="checkbox"/> Physiotherapy assessment  | <input type="checkbox"/> Risk Assessment (attached)                              |
| <input type="checkbox"/> Nursing assessment        |  |

**Please attach results of above. Please return copy of Brief Risk Assessment (attached).**

<b>BRIEF RISK ASSESSMENT</b>	Surname:	Male: <input type="radio"/>	Female: <input type="radio"/>
	Forenames:	Date of Birth:	
	Patient's Address:		

<b>Source of Information</b>	The consumer: <input type="radio"/>	Immediate carer (parent, spouse, child): <input type="radio"/>
Other informants (family, friends): <input type="radio"/>	Previous clinical records: <input type="radio"/>	Assessing clinician's knowledge of consumer's past behaviour/current clinical presentation: <input type="radio"/>
Police/ambulance/other agencies: <input type="radio"/>	Other (please specify):	

<b>SUICIDALITY Static (historical) factors</b>	<b>Yes (1)</b>	<b>No (0)</b>	<b>Not Known</b>	<b>Dynamic (current) risk factor</b>	<b>Yes (2)</b>	<b>No (0)</b>	<b>Not Known</b>
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			

<b>PROTECTIVE FACTORS (describe):</b>	
<b>LEVEL OF SUICIDE RISK (total score):</b>	Low (<7) <input type="radio"/> Moderate (7-14) <input type="radio"/> High (>14) <input type="radio"/>

<b>AGGRESSION/VIOLENCE Static (historical) factors</b>	<b>Yes (1)</b>	<b>No (0)</b>	<b>Not Known</b>	<b>Dynamic (current) risk factor</b>	<b>Yes (1)</b>	<b>No (0)</b>	<b>Not Known</b>
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			

<b>PROTECTIVE FACTORS (describe):</b>	
<b>LEVEL OF VIOLENCE RISK (total score):</b>	Low (<7) <input type="radio"/> Moderate (7-14) <input type="radio"/> High (>14) <input type="radio"/>

<b>OTHER RISKS IDENTIFIED (AND RISK FACTORS):</b>	
<b>RISK MANAGEMENT ISSUES: (please ensure alerts are noted here)</b>	

<b>TO BE COMPLETED BY ASSESSING CLINICIAN</b>			
Print Name:	Designation:	Signature:	Date:

<b>Where appropriate, management plan to be acknowledged by requesting medical practitioner</b>			
Print Name:	Designation:	Signature:	Date: