Bury Neighbourhood Mental Health Service

BURY INTEGRATED CARE PARTNERSHIP

Referral form

Important information:

- It's important the patient has been informed about the service remit, data protection, and when information may be shared.
- Consent needs to be obtained before referral.
- All sections must be completed in full and compliant with these requirements.
- Failure to do so may result in delays or the form being returned.
- By submitting this form, you confirm these discussions have taken place.
- The neighbourhood mental health team is for **routine referrals only**. Please refer to the crisis pathway if you need a more urgent response.
- To tick the yes/no boxes, click the applicable box.
- If you need help completing this form, a **guide is available here**.

Section 1

Consent	
Has the individual been informed of and consented to contact being made with other health professionals or organisations involved in their care regarding their mental health needs?	**Yes** ☐ **No** ☐
Do they consent to this referral being shared with other NHS-affiliated organisations, where appropriate, to support their care and treatment?	**Yes** ☐ **No** ☐
If ticked no, please include rationale:	
Does the individual consent to their information being stored and shared, where appropriate, on systems used by partner agencies involved in their care (which may include non-NHS services), to support their ongoing treatment and support needs?	**Yes** ☐ **No** ☐
Has the individual been informed that if there are serious concerns about their safety or the safety of others, emergency services may be contacted?	**Yes** ☐ **No** ☐

Referral source			
Referrer name:		Address:	
Telephone:		Service:	
Email address:			

General practice details		
Referring name:	Referrer code:	Practice code: Usual GP Organisation National Practice Code
Registered GP: Registered GP Title Registered GP Surname	Surgery name: Usual GP Organisation Name	Surgery Address: Usual GP Full Address (stacked)
Surgery telephone number: Organisation Telephone Number	Surgery email address: Organisation E-mail Address	

Patient details		
Referral date: Short date letter merged	Priority:	NHS number: NHS Number
Title: Title	Forename: Given Name	Surname: Surname
Date of birth: Date of Birth	Gender: Gender(full)	Ethnicity: Ethnic Origin
	Preferred pronouns:	
Address: Home Full Address (stacked)	Home telephone number: Patient Home Telephone	Email: Patient E-mail Address
	OR Mobile telephone number: Patient Mobile Telephone	Text message consent: Yes ☐ No ☐
	Voicemail consent: Yes ☐ No ☐	
	Interpreter required: Yes ☐ No ☐	If yes, language:
Special appointment requests: any details patient provides regarding appointments e.g. working, can only attend early or late. next of kin details if relevant. Please include any relevant safeguarding and power of attorney information.		

Tick if pregnant or has children under the age of 2 years:	Yes ☐ No ☐
Tick if individual has served in the armed forces (veteran):	Yes ☐ No ☐
Emergency contact details: Name, relationship, contact number and address	

Section 2

Referral information	
What is the reason for the referral to mental health services?	
Is the individual open to any other services? Have any other referrals been made to other services?	
Are there any known concerns, such as vulnerability, self-neglect, safeguarding issues, or behaviours that may impact the individual's safety or ability to engage with support services? This includes concerns about harm to self or from others. Please give as much detail as possible including likelihood and frequency. If you have any safeguarding concerns about any adult or child, please follow your local safeguarding procedures	
Does the patient have any caring responsibilities (children or adults with support needs)? Please provide details.	
Current medication: Please provide medication details and state if they are adherent.	
Medical history, including mental and physical issues:	
Allergies?	
Is the individual currently using drugs, alcohol, or unprescribed medication? If so, please provide details.	
Yes ☐ No ☐	
Reasonable adjustments	
Does this person have accessibility needs or require any reasonable adjustments such as preferred communication styles, neurodiversity, cognitive decline, learning or physical disabilities. Language barriers should be considered to ensure meaningful, individualised engagement.	

Please advise of the impairment and the adjustment required; please add any existing reasonable adjustment already known or recorded.
Equal opportunities
Ethnicity: **Employment status:** **Marital status:** **Religion:** **Disability:** **Pregnant:** Yes ☐ / No ☐ **Communication difficulties:** Yes ☐ / No ☐ If yes, please provide information: **Sexual orientation:** Lesbian ☐ Gay ☐ Bisexual ☐ Heterosexual ☐ Other ☐ Prefer not to say ☐