Referral Form for Mental Health (Pennine Lancs) This referral should be submitted to **lcn-tr.mentalhealthreferrals@nhs.net** **Tel: 01282 657116**	***Provider use only*** **Appointment Date:** **Time:** **Confirmed**

Do not use this template for Dementia Referral Services as there is a separate form

Service Requested

☐ Symptoms or areas of risk suggesting a Specialist Triage Assessment Referral Treatment Team (START) referral are:

- Violence or self-harm
- Suicide Intent
- Voicing threats or intent to inflict harm on others
- Florid psychiatric symptoms
- Serious self-neglect
- History of serious mental health problems where relapse triggers relating to risk have been previously identified

☐ Main Access Point (Older Adult)

☐ Early Intervention Service (first episode psychosis only)

Mindsmatter Talking Therapies (CBT Counselling) *To refer to Mindsmatter please advise self-referral*

Your referral will be prioritised and processed to the appropriate team.

Patient Details:	Referral Date:	
Name:	DOB:	Gender:
Address:		
NHS Number:	Telephone Number:	
Marital Status:	Interpreter Required: **Y** ☐ **N** ☐ Language	
Ethnicity:		
Does the patient consent to this Referral? **Y** ☐ **N** ☐		
If they do not consent do they have capacity? **Y** ☐ **N** ☐		
Is the patient available for the next 4 weeks? **Y** ☐ **N** ☐ Dates unavailable:		
Does the patient live alone? **Y** ☐ **N** ☐		
Does the patient have Children/Dependants? **Y** ☐ **N** ☐		
Referring Clinician / GP Details		
Referring Clinician: Position / Organisation:		
Name:		
Address:		
Telephone:	E-mail:	

Carer / Next of Kin Details

If carer / NOK details are not known please add an agreed contact person's details here: