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