 

Primary Care Centre, Golf Links Road, Roscommon **Tel:** 090 6665020 **Fax:** 090 6627293

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| **REFERRAL FORM** | | | | | | | | | | | | | |
| **DETAILS OF PERSON BEING REFERRED** | | | | | | | | | | | | | |
| Name |  | | | | | Date of birth | | | | /     / | | | |
| Address |  | | | | | | | | | | | | |
| Sex | Male |  | Female |  |  | GMS No. (IF APL.) | | | | | |  | |
| Phone No. | Landline | |  | | | Mobile | | |  | | |  | |
| Does this person have special needs?  (e.g., requires wheelchair access) | | | | | |  | | | | | | | |
| **REFERRER DETAILS** | | | | | | | | | | | | | |
| Referrer name | | |  | | | | | | | | | | |
| Professional title | | |  | | | | | | | | | | |
| Address of referrer | | |  | | | | | | | | | | |
| Telephone/Mobile No. | | |  | | | | | Fax no. | | |  | | |
| Signature: | | | | | | | |  | | | | | |
| Date:      /     / | | | | | | | |  | | | | | |
| **GP DETAILS (if different from above)** | | | | | | | | | | | | | |
| Name of GP | | |  | | | | | | | | | | |
| Address of GP | | |  | | | | | | | | | | |
| Telephone/Mobile no. | | |  | | | | | | | | | | |
| **REASON FOR REFERRAL** | | | | | | | | | | | | | |
| Please describe the main presenting difficulties the person being referred is currently experiencing, the severity of these difficulties, and the duration: | | | | | | | | | | | | | |
| **RECENT STRESSORS** | | | | | | | | | | | | | |
| Are there any current or recent events/circumstances that may act as a significant source of stress for the person? If so, please specify: | | | | | | | | | | | | | |
| **RISK ASSESMENT** | | | | | | | | | | | | | |
| Current suicidal intent | | | | |  | | Deliberate self-harm | | | | | |  |
| Current suicidal risk | | | | |  | | Risk of violence | | | | | |  |
| Previous psychiatric hospitalisation | | | | |  | | Current self-neglect | | | | | |  |
| Previous suicide attempt | | | | |  | | If present, number of attempts: | | | | | | |
| **If urgent care is needed in relation to risk, please telephone the mental health acute unit (County Hospital, Roscommon) at 090 663 2325 (24 hrs).** | | | | | | | | | | | | | |
| **MENTAL HEALTH TREATMENT** | | | | | | | | | | | | | |
| Is this person currently receiving treatment from another mental health service or have they been referred to another mental health service? If so, please specify: | | | | | | | | | | | | | |
| Is this person being treated with medication for their mental health difficulties? If so, please specify: | | | | | | | | | | | | | |
| **MEDICAL HISTORY AND CURRENT TREATMENT** | | | | | | | | | | | | | |
| Please provide details of any relevant medical problems and any current medication/treatment? | | | | | | | | | | | | | |
| **SUGGESTED TREATMENT** | | | | | | | | | | | | | |
| Counselling  Therapist-assisted psycho-education  Computerised CBT  Brief one-to-one CBT  Psycho-educational group workshop | | | | | | | | | | | | | |
| **SERVICE USER CONSENT** | | | | | | | | | | | | | |
| Service user consents to be contacted by: (Tick as appropriate)  Landline  Mobile  Letter | | | | | | | | | | | | | |