 

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 [ ]  |