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| **Forensic Community Service****Forensic Liaison Clinic** **Referral Form** |

A Complete

**Referral Criteria**

Before completing the referral, please check the following boxes to ensure criteria are met.

* Patient is aged 18 and over [ ]
* Patient has a **primary** diagnosis of mental illness [ ]
* Patient has a named Care Co-ordinator [ ]
* Patient is open to secondary mental health services [ ]
* Patient is demonstrating significant actual or potential risks to others [ ]
* Patient is in the community or preparing for discharge [ ]

**Guidance notes for completing Referral Form**

The Forensic Community Service (FCS) requires specific information to proceed with a referral.

Please ensure that all sections are completed.

Please do not state “refer to RiO/PARIS” as this will unfortunately result in the uncompleted document being sent back to the referrer.

Please ensure that the form is typed, not handwritten. Boxes will expand upon typing.

**On Completion**

Completed forms should be emailed to: forensiccommunityreferrals@cntw.nhs.uk

Following discussion in our team meeting, we will then be in touch to advise you of the outcome. We hold Forensic Liaison Clinics to discuss referrals to the service, you may be offered an invitation to attend this to discuss the referral further. Prior to the meeting you may be asked to gather more information.

Forensic Liaison Clinics (FLCs) occur every Wednesday morning.

**Queries**

Forensic Community Service (North Team),

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust,

Forensiccommunityservice@cntw.nhs.uk

0191 2467273.

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| **Name** |  | **DoB (and age)** |  |
| **RiO Number** |  | **PARIS Number** |  |
| **NHS Number** |  | **MHA Status** |  |
| **Gender** |  | **Ethnic Origin** |  |
| **Current location** |  |
| **Care Co-ordinator** |  | **Consultant Psychiatrist(s)** |  |
| **Current CTT /CMHT****(if applicable)** |  |
| **Local Authority** |  | **Who is allocated from the LA?** |  |
| **Other Key Clinicians and Teams Involved** |  |
| **Is the patient known to MAPPA/MARAC?** | **Yes** |[ ]  **No** |[ ]  **If yes, what Level?** |  |
| **Referrer(s)** |  |
| **Referrer Address & Contact Details** |  |
| **Please include a second contact name and email (in case of absence)** |  |
| **Date Completed** |  |
| **Is the patient aware of the referral?** | **Yes** |[ ]  **No** |[ ]  **If No, why?** |  |

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| **Reason for Referral. What is the behaviour of concern currently?** |
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| **Diagnosis** |
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| **Risk Summary** |
| **Risk (check the box if it applies and add narrative below)** |
| Offending behaviour  |[ ]  Stalking/Harassment |[ ]
| Sexual offending  |[ ]  Substance Misuse |[ ]
| Domestic Violence |[ ]  Safeguarding Adult issues |[ ]
| Harm to others |[ ]  Safeguarding Children issues |[ ]
| Fire setting |[ ]  Current or past neglect |[ ]
| Self-harm |[ ]  Other |[ ]
| **Previous Criminal/Offending History** ***\* Include violent behaviours/ideas; severity; location; circumstances; precipitants etc.*** ***\* Is the patient involved with Probation?****\** ***Are there any outstanding/pending criminal procedures?*** |
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| **Current Risk Assessment and Management Plan** |
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| **What would you like us to focus on?** **What do you hope we can achieve during the FLC?** |
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| **Case Summary** |
| **Background History*****(Family/personal/developmental/social history)*** |
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| **Psychiatric History** ***(Including presenting features, diagnoses, treatments, outcome for each episode)*** |
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| **Drug and Alcohol History** |
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| **Medical/ Physical Health History and Needs** |
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| **Current Medication** |
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| **Recent Mental State Examination including date completed** |
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| **Previous involvement with Forensic Services** |
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| **Previous history in relation to engagement with Services** |
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| **Any further information that may be helpful to the Forensic Community Service?**  |
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