

**HARTS LEAP INDEPENDENT HOSPITAL
REFERRAL FORM**

Please complete all sections and attach copies of any relevant reports

Details of referred person

TITLE: Mr Mrs Ms Other

Name:
Date of Birth:
Diagnosis:
Legal Status:
RMO Consultant:
Current Placement:
Telephone:
Marital Status:
Religion:
Ethnic Group
Next of Kin:

Referral made by: (designation and contact number)	Name:
	Address:
	Telephone:
	Email:



REASON FOR REFERRAL

--

ARE THE FOLLOWING PEOPLE AWARE OF THIS REFERRAL?

Person referred **Yes/No**

Family **Yes/No**

Funding Authority **Yes/No**

BRIEF PSYCHIATRIC HISTORY

MEDICAL HISTORY

CURRENT MEDICATION

CURRENT MENTAL HEALTH

--

UNTOWARD INCIDENTS IN THE LAST SIX MONTHS

Aggression	
Absconding	
Arson	
Self Harm	
Sexual	
Other	
Present Risk Behaviours	

FUNDING INFORMATION

Funding Authority	
Is Funding Agreed	
Contact Name	
Address	
Telephone	
Fax	
Email	
Date	
How did you hear about Harts Leap Independent Hospital?	

Please return this completed form to:

*Jo Rolt
PA to Hospital Director
Harts Leap Independent Hospital
Windrush Heights
Berkshire
GU478ET
Tel: 01344772599 extension 26
Fax: 01344 466378*

Please send care plans and any other relevant reports with this referral form. We will acknowledge the referral on receipt and would hope to complete any assessment within 5 working days.

Thank you for completing this referral form