**MID & SOUTH ESSEX ARMS (AT RISK MENTAL STATE FOR PSYCHOSIS) SERVICE REFERRAL FORM**

|  |
| --- |
| **Date:** |
| **Please note that ALL sections must be completed** |
| **Title:**  | **First Name:** | **Surname:** |
| **Preferred Name:**  | **Date of Birth:** |
| Address and Postcode: | Preferred Pronouns: |
| NHS Number: |
| Home Telephone: |
| Mobile Number: |
| Preferred Email Address: |
| Preferred Language: | Is an interpreter required: |
| Ethnicity: | Nationality: | Religion: |
| *Please indicate* ***consent*** *for us to communicate by* *Letter:* [ ] *Email:* [ ] *Phone:* [ ]  *(includes if another person answers your phone)**Leave Phone Message or SMS:* [ ]  |
| **Next of Kin** (compulsory for under 16’s)**:****Relationship to individual:****Address:****Home Telephone:****Mobile:** | **GP Name:** |
| **GP Address:****Telephone** |
| **School/Education Provider: (if applicable)** |
| **Employment:** |
| **Please identify any decline in functioning over the past 12 months that has lasted longer than 4 weeks** (Please note that we only accept referrals when there has been a significant decline in functioning or low functioning has been sustained for over a year)  |
| **Difficulties with relationships/family/friends:** [ ] **Difficulties at school/education:** [ ] **Difficulties at Work:** [ ] **Struggling with Self-care:** [ ] **Ability to access the community/socialize:** [ ]  |
| **Please provide additional details of the decline in functioning or describe other changes in functioning not covered above.** |
|  |
| **Does the person have a first degree relative with diagnosis of psychosis or schizotypal personality disorder? Please provide details.** |
|  |
| **Description of current situation**Please indicate which have been mentioned by the individual  |
| [ ] Family/friends are concerned[ ] Excessive use of alcohol [ ] Use of illicit drugs [ ] Arguing with friends/family.[ ] Spending more time alone [ ] Feeling people are watching them [ ] Feeling/Hearing things others cannot | [ ] Sleep difficulties[ ] Poor appetite[ ] Depressive mood[ ] Poor Concentration[ ] Restlessness[ ] Tension or Nervousness[ ] Less pleasure from things | [ ] Ideas of reference[ ] Unusual beliefs[ ] Odd manner of thinking/speech[ ] Inappropriate affect[ ] Out of character behaviour or appearance |
| *Please mention any other difficulties not indicated above, and detail any further information such as when any of these experiences started and how long they typically last for:* |
|  |
| **Describe any risk to self and others** Please indicate all relevant risk factors  |
| [ ] Suicide[ ] Deliberate Self-Harm [ ] Accidental Self-Harm ☐Self-Neglect[ ] Health/Medical Conditions[ ] Aggression/Harm to Others | [ ] Exploitation/Domestic Violence[ ] Offending Behaviour/Forensic History[ ] Difficulties with caring for dependents[ ] Difficulties with engaging with services[ ] Through Use of Alcohol[ ] Through Use of Drugs |
| *Please mention any other risks not indicated above, and detail any further information regarding the nature of risks highlighted* |
|  |
| **Current/Previous treatment (if any)** (Are they known to any other services? Please include both psychological interventions and medications prescribed) |
|  |
| **Consent of child/young person or parent/carer with parental responsibility (PR)*****We can only proceed*** *with the consent of the individual* ***or*** *if under 16, a parent/carer with parental responsibility.* |
| **Child/Young Person Under 16**1. Does the parent/carer consent to this request for support? Yes [ ]  No [ ]
2. Does the parent/carer consent to the sharing of information with other NHS Services that care for the child? Yes [ ]  No [ ]
3. Does the parent/carer of the child consent toinformation being shared with other teams and agencies (e.g. Education services, Children’s Centres and social care) in order to identify the most appropriate support? Yes [ ]  No [ ]

  |
| **Signed (Parent/Carer)****…………………………………………………………..** | **Comments, if any****………………………………………………………………………** |
| **Individual Over 16** 1. Does the individual consent to this request for support? Yes [ ]  No [ ]
2. Does the individual consent to sharing of information with other NHS Services that care for them? Yes [ ]  No [ ]
3. Does the individual consent to information being shared with other teams or agencies (e.g. Education services, Children’s Centres and social care) in order to identify most appropriate support. Yes [ ]  No [ ]

  |
| **Signed (Parent/Carer)****…………………………………………………………..** | **Comments, if any****………………………………………………………………………** |
| **Person Completing Referral Form / Referral Source (***Please tick boxes below***)** |
| **Self:** [ ] **Family:** [ ] **Professional:** [ ] **Other:……………………………………………………………………………………………………….** |
| **Name:** |
| **Telephone:** | **Email:** |
| **Organisation:**  | **Address:** |
| **Signed:** | **Date:** |

**Please email completed form to:** **epunft.msearms@nhs.net** **Telephone: (01376) 522300 option 3**