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

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| --- | --- | --- | --- | --- | --- | --- |
| **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 these changes 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**](mailto:epunft.msearms@nhs.net) **Telephone: 01375 809700**