**Referral form for Memory Assessment Services**

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| **NB All referrals to the Memory Assessment Services will be seen as a routine appointment. We do not have an urgent pathway in Memory Services.** |

**Single Point of Access (SPOA) details**

 **Direct telephone number: 0121 301 4000**

**Direct E-Fax number: 0121 301 4001**

 **Secure email:** **bsm-tr.referrals@nhs.net**

**Opening hours: Monday to Friday 8am to 7pm**

**For urgent referrals outside of these hours:**

 **Please contact BSMHFT central switchboard on 0121 301 5500**

**and ask for your local Home Treatment team**

**Referrals may be returned, if there is insufficient information to allow triage**

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| **Patient details - *please insert the details directly from your clinical system*** | **Referrer details** |

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| **Full Name:** |  | **D.O.B:** | **Registered GP name & address:** |
| **Address:** |  | **Gender:** |
| **Age:** | **Referring GP:** |
| **Home Tel No:** |  | **NHS No:** | **Practice code:** |
| **Mobile Tel No:** |  | **Marital status:** | **Referring GP telephone no:**  |
| **Ethnicity:** |  | **Main language** |  | **Interpreter required?**  | **Yes/No** |
| **Disability:** | **Hearing ☐ Sight ☐ Physical ☐ please expand, if necessary :**  |
| **Consent:** | **Has your patient consented to this referral: Yes/No,** **if no please specify the reason below:** |
| **Review:** | **Please confirm the date your patient was last seen face to face by the referring GP:** |
| **Support:** | **Please provide the name, relationship and contact number of any person supporting your patient in respect of this referral, who SPOA can contact, if necessary:**  |

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| ***Is this patient known to the mental health services*** *Yes ☐ No ☐,* ***if yes, and the patient is actively in treatment, you do not need to re-refer via SPOA, please contact the current team directly, to avoid any further delay*** |

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| **Reason for referral to Memory Services – Referrals may be declined without this information**  |
| **Duration of memory problems****Please provide examples of issues with memory, language or other thinking skills****Is there some evidence that there has been a decline from a previously better level of functioning please comment regarding ADL’s ie care package in place, are they independent in self-care, cooking household tasks etc****Any evidence of self-neglect:****Any risks or safety concerns please describe these:****Does the person drive any issues with safety or losing their directions:****Is there any evidence of mood or thought disorder if so what are these symptoms and how is it affecting daily living:****Any challenging behaviours****Is cognitive impairment likely due to intoxication with alcohol or other substances****Are there any contact numbers for next of kin****PHQ Score:****MMSE Score and/or 6 Item Cognitive Impairment Test/GP COG/ AMT:** |
| **Important Information of note Safeguarding, exploitation, domestic violence etc :** |
| ***Please provide a narrative of your actions in relation to this referral and full details of people affected, to include names and date of birth, specifically in relation to child/adult safeguarding, exploitation, domestic violence etc., that may impact on the patient’s mental state and our assessment:*** |
|  **Risk to self or others - please use the risk tool below:***Please ensure you answer all of the following for the safety of patient, staff and the public::* |
| 1. **Is the person expressing thoughts of suicide or self-harm?**
2. **Has the person ever made a suicide or self-harm attempt?**
3. **Is the person expressing thoughts or has previously engaged in episodes of violence/aggression?**
4. **Is the home environment safe to visit?**
5. **Is there concern about harm or exploitation from others e.g. domestic violence, sexual harassment or abuse, financial abuse? (If yes, please provide further details within important information below)**
6. **Are there any child protection/safeguarding issues? (If yes, please provide further details within important information below)**
7. **Is the person at risk of self-neglect, physically or emotionally?**
8. **Is there concern about the person’s concordance with existing mental-health treatment?**
9. **Is there concern about the person’s general current behaviour e.g. risk taking, sleep pattern, activities of daily living? (If yes please provide further details within important information below**
10. **Is there a history of misusing drugs or alcohol?**
11. **Is there a history of depression or serious mental illness, including any current episode?**

***Where you have answered yes to questions 5 and 6 please ensure you provide additional information in the ‘Important Information’ box below – Please note, referrals will be returned if this information is not included*** | **Yes No Not Known**☐ ☐ ☐☐ ☐ ☐☐ ☐ ☐☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐☐ ☐ ☐☐ ☐ ☐ ☐ ☐ ☐☐ ☐ ☐  |

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| **Most recent blood investigations** (Please upload latest results directly from GP system) |
| Please confirm if dementia screening bloods have been completed and are within the last 3 months:☐ Yes, **please attach** ☐ No please arrange and forward results to MAS fax no: 0121 301 0940 ☐ FBC ☐ U &E’s ☐ TSH ☐ B12 ☐ Folate ☐ LFT ☐ TFT ☐ HbA1c ☐ Calcium ☐ ESR |
| **Problem list and significant Past medical history** (Please upload latest results directly from GP system) |
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| **Current medication being prescribed at date of referral** (please upload directly from GP system) |
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| **Confirmed allergies at date of referral** (please upload directly from GP system) |
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| **Recent diagnostics** (Please upload latest results directly from GP system) |
| **Blood Pressure:** **Weight:** **BMI :** **Alcohol:** **Illicit Substances:** |