Inpatient Referral Form

Adult Mental Health Services

St John of God Hospital

You may also refer electronically by searching "St John of God Hospital" on HealthLink or your GP practicemanagement system such as Socrates or Healthone.

Please complete all sections fully and submit to:

Admissions Office, St John of God Hospital, Stillorgan, Co. Dublin, A94 FH92. **Email:** referrals@sjog.ie

Referral Priority:

Urgent: ☐ Routine: ☐

Patient Details

Full Name:

Date of Birth:

Gender: Male: ☐ Female: ☐ Other: ☐ *(If other, please elaborate)*

Address:

Contact Number 1:

Contact Number 2:

Email:

Referrer's Details:

Name:

Practice/Address:

Contact Number:

Email:

Is this person related to you in any way? Yes ☐ No ☐

GP Details (if different to referrer's details):

Name:

Practice Address:

Contact Number:

Email:

Insurance Details:

Insurance Cover: Yes ☐ No ☐

Health Insurance Provider:

Irish Life Health ☐ Laya Healthcare ☐ VHI Healthcare ☐ Level Health ☐

Other (please specify):

Policy Number (if available):

Date of Onset of Present Complaint:

Is the person you are referring currently attending another mental health service/specialist?

No ☐ Yes (please specify):

Reason for Referral

Please include your reason for referral.

Past Psychiatric History

If available: Please include copies of previous correspondence and details of previous admissions, previous medications and/or psychological treatments.

Relevant Family History & Current Social Circumstances

Current Medications

Please include precise strength, dosage and any known allergies/adverse reactions

Risk Assessment

Vulnerabilities

- ☐ Physical illness
- ☐ Financial distress
- ☐ Harassment
- ☐ Decline in hygiene
- ☐ Confusion
- ☐ Memory problems
- ☐ Disability
- ☐ Homelessness
- ☐ Stigmatization
- ☐ Poor self-care
- ☐ Poverty
- ☐ Abuse
- ☐ Falls
- ☐ Lack of supports
- ☐ Exploitation
- ☐ Poor food intake
- ☐ Bullying

☐ Other *(Or if any box is checked above please elaborate)*

Self-Harm/Suicidal Tendencies

- ☐ Previous suicide attempt(s)
- ☐ Ongoing suicidal ideation
- ☐ Hopelessness
- ☐ Concern from others about risk of suicide/deliberate self-harm
- ☐ Major life changes or challenges
- ☐ Previous self-harm
- ☐ Suicidal gestures
- ☐ Previous suicide in family/circle of friends
- ☐ Opinion of the referrer that there is a risk of suicide or deliberate self-harm

☐ Other *(Or if any box is checked above please elaborate)*

Mental Instability:

- ☐ Intense and obvious symptoms of mental illness:
- ☐ Risk-taking behaviours
- ☐ Bizarre behaviours
- ☐ Sexually disinhibited
- ☐ Overspending
- ☐ Anger/aggression
- ☐ Impulsivity
- ☐ Increased alcohol/drug use
- ☐ Not following medical or legal advice

☐ Other *(Or if any box is checked above please elaborate)*

Risk to Others:

- ☐ Recent/past history of violence
- ☐ Poor self-control when angry
- ☐ Antisocial tendencies
- ☐ Possession of/access to weapons
- ☐ Current thoughts, plans, or symptoms of violence
- ☐ Known risk to vulnerable adults/children
- ☐ Expressed concern from others about risk of violence
- ☐ Current behaviour suggesting risk of violence
- ☐ Opinion of the referrer that there is a risk of violence

☐ Other *(Or if any box is checked above please elaborate)*

Forensic History:

Does this person have any forensic history?

☐ Yes, *provide details below* ☐ No

Details:

Pending Charges

Are any charges pending against this person?

☐ Yes, *provide details below* ☐ No

Details:

Declaration

I understand that I retain clinical responsibility for this patient until they are clinically assessed in person by a St John of God Hospital clinician.

Signature:

Date: