Saint John of God Hospital and Ginesa Suite

Dear Referrer,

Please complete all sections in full.

Thank you.

Referral Priority	☐ Urgent	☐ Priority	☐ Routine
Service(s) Required	☐ In-patient Admission	☐ Psychiatry OPD	☐ Remote EDP
Select all required	☐ Athrú Day Hospital	☐ Psychology OPD	

Patient's Details			
Name	Click to enter text	Gender	☐ Male ☐ Female
Address	Click to enter text	Has this person been admitted to Saint John of God Hospital before?	☐ Yes ☐ No ☐ Unknown
Date of Birth	Click to enter date	Telephone	Click to enter text

Referrer's Details			
Name	Click to enter text	Telephone	Click to enter text
Practice/Address	Click to enter text	Fax	Click to enter text
		E-mail	Click to enter text
Is this person related to you in any way?		☐ Yes ☐ No	

GP Details (if different to Referrer's Details)			
Name	Click to enter text	Telephone	Click to enter text
Practice/Address	Click to enter text	Fax	Click to enter text
		E-mail	Click to enter text

Insurance Details	
Insurance Cover	☐ Yes ☐ No ☐ Unknown
Health Insurance Provider (please tick insurer)	☐ Irish Life Health ☐ Laya Healthcare ☐ VHI Healthcare ☐ Unknown ☐ Other, *please specify* Click to enter text
Insurance Policy Number (if available)	Click to enter text

Reason for Referral

NB Please complete the Addictions Specific Information Section below if the primary complaint is addictions.

Click to enter text

Date of Onset of Present Complaint Click to enter text

Addictions Specific Information

Addictions Details: Please include substances used, duration, route and previous treatment(s).

Click to enter text

Medical and Surgical History

Please include discharge summaries if admitted to hospital in the past year and copies of blood test results from the past month.

Click to enter text

Hep B

☐ Yes ☐ No

Hep C

☐ Yes ☐ No

HIV

☐ Yes ☐ No

Mobility Issues

☐ Yes - wheelchair user
☐ Yes - other, *please specify* Click to enter text
☐ No

Requires Assistance with ADLs

☐ Yes, *please specify* Click to enter text
☐ No

Allergy/Adverse Reactions (PLEASE TICK ONE BOX BELOW)

☐ Yes ☐ NKDA (No Known Drug Allergy)

IF YES: Please specify medicine(s) and nature of reaction

Click to enter text

Current Medications

Please include precise strength and dosage.

Click to enter text

Past Psychiatric History

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

Click to enter text

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

☐ Yes, *please specify* Click to enter text
☐ No

IF YES: Has the referral to Saint John of God Hospital been discussed with the person's current consultant/ specialist and are they happy with this referral?

☐ Yes
☐ No

IF YES: Medical notes and referral confirmation are required from the person's current treating service.

Relevant Family History & Current Social Circumstances

Click to enter text

Physical Health Assessment [for referrals to Athrú Day Hospital and Remote EDP]

Please include and attach all recent tests/investigations ☐ Attached

Blood pressure, height, weight, waist circumference, laboratory results, ECG, urinalysis, physical review, etc.

Click to enter text

Risk Assessment	
Saint John of God Hospital strives to provide a safe therapeutic environment for every person under our care. One aspect of managing safety is the formulation of an individual and dynamic risk management plan for each patient, which is regularly discussed and updated as part of their overall care plan. You can help us by letting us know about any concerns you may have in relation to your patient's safety, or about any risks you believe your patient may be exposed to. Your concern may be covered by one or more of the areas described below, or may involve additional areas. If you have additional or new concerns during your patient's stay in hospital, feel free to submit the risk assessment form as often as necessary. Please be aware that your comments may be discussed with/or accessed by your patient. **Please consider the following when completing the risk assessment (please explain in the spaces provided when box ticked). NB: Not completing this section in full may result in a delay to admission.**	
Vulnerability	☐ Physical illness ☐ Memory problems ☐ Poverty ☐ Poor food intake ☐ Financial distress ☐ Disability ☐ Abuse ☐ Bullying ☐ Harassment ☐ Homelessness ☐ Falls ☐ Other, *please specify* Click to enter text ☐ Decline in hygiene ☐ Stigmatization ☐ Lack of supports ☐ Confusion ☐ Poor self-care ☐ Exploitation
Self-Harm/Suicide	☐ Previous suicide attempt(s) ☐ Previous suicide in family/circle of friends ☐ Major life-changes or challenges ☐ Previous self-harm ☐ Concern from others about risk of suicide/ deliberate self-harm ☐ Other, *please specify* Click to enter text ☐ On-going suicidal ideation ☐ Opinion of the referrer that there is a risk of suicide or deliberate self-harm ☐ Suicidal gestures ☐ Hopelessness
Mental Instability	Intense and obvious symptoms of mental illness: ☐ Risk taking behaviours ☐ Overspending ☐ Increased alcohol/drug use ☐ Other, *please specify* Click to enter text ☐ Bizarre behaviours ☐ Anger/aggression ☐ Not following medical or legal advice ☐ Sexually disinhibited ☐ Impulsivity

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, *please specify* Click to enter text

Does this person have any forensic history? ☐ Yes, *please provide details below* ☐ No

Click to enter text

Are any charges pending against this person? ☐ Yes, *please provide details below* ☐ No

Click to enter text

Form Completed By			
Name & Professional Registration Number	Click to enter text	Date	Click to enter date

For Internal Use Only
Are any significant risk factors highlighted? ☐ Yes ☐ No ***IF YES:*** Have these risk factors been discussed with the nurse in charge of the admitting suite? ☐ Yes Suite _____ Name of Nurse _____