Inpatient Referral Form

Adolescent Mental Health Services

St John of God University Hospital

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

Please complete all sections fully and submit to:

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

Referral Priority

Urgent: ☐ Routine: ☐

Patient Details

Full Name:

Date of Birth:

Gender:

Address:

Contact Number 1:

Contact Number 2:

Email:

Parent/Guardian Details

Name(s):

Address (if different):

Contact Number:

Email:

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

Legal Guardianship: Sole ☐ Joint ☐ Care Order ☐

Referrer's Details

Name:

Address:

Contact Number:

Email:

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

GP Details (if different from Referrer's)

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

○ Other, please specify *(Or if any box is checked above please elaborate)*

Self-Harm/Suicidal Tendencies

- ○ Previous suicide attempt(s)
- ○ Previous self-harm
- ○ Ongoing suicidal ideation
- ○ Suicidal gestures
- ○ Hopelessness
- ○ Previous suicide in family/friend groups
- ○ Concern from others about risk of suicide/deliberate self-harm
- ○ Poor food intake
- ○ Bullying
- ○ Opinion of the referrer that there is a risk of suicide or deliberate self-harm
- ○ Major life changes or challenges

○ Other, please specify *(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, please specify *(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 others
- ○ 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 *(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:

Please complete if this referral relates to an eating disorder

Current Physical Observations

Current Weight (Kg):

Height (cm):

BMI/ % or WFH:

Blood Pressure:

Lying Heart Rate:

Standing Heart Rate:

Date of last blood test/ abnormalities:

Date of last ECG:

Eating Disorder Behaviours

Behaviour	Yes	No	Details
Restrictive intake	○	○	
Binge eating	○	○	
Excessive exercise	○	○	
Vomiting/purging	○	○	
Laxative/medication	○	○	

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

Declaration

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

Signature:

Date: