

# PATIENT REFERRAL FORM



Please complete all sections and fax to:  
**Referrals Team on Safehaven Fax 01904 430906**

REFERRER'S DETAILS	
NAME OF REFERRER:	DATE:
NAME OF ORGANISATION:	CONTACT TEL:
ADDRESS:	
POSTCODE:	
E-MAIL:	

PATIENT'S DETAILS	
NAME:	DATE OF BIRTH:
NHS No:	UNIQUE PATIENT No:
WHERE IS THE PATIENT NOW?	HOME ADDRESS:
	POSTCODE:
GP'S NAME:	GP'S ADDRESS:
GP'S TEL:	POSTCODE:

CLINICAL DETAILS
WHAT IS THE CLINICAL PROBLEM?
CURRENT MENTAL STATE / MHA STATUS / LEVEL OF OBSERVATION:
CURRENT MEDICATION:
REASON FOR REFERRAL:

## FUNDING INFORMATION

WHO WILL FUND THE PLACEMENT AT THE RETREAT? PCT / Trust / Private	IS FUNDING AGREED? YES / NO
NAME OF FUNDING AUTHORITY:	CONTACT NAME:
CONTACT ADDRESS:  POSTCODE:	CONTACT TEL:

### **PLEASE ENSURE YOU ATTACH SUPPORTING REFERRAL DOCUMENTATION ie Psychiatric Reports, Risk Assessment Reports, Social Care Reports**

This information will be held securely under the Data Protection Act 1998. The information will not be shared with any third parties without further consent from the originating organisation. Your details will be held in a database and may be used for marketing purposes by The Retreat. If you object to us sending you details of our services, please tick here.

Thank you. We will contact you by the end of the next working day.