**AMHP Referral Form**

* All referrals to be emailed to the relevant address (below)
* All referrals to be followed up with a phone call to confirm receipt of the referral form by the AMHP/EDT Service. This enables discussions with the referring professional and supports the review of the referral.
* All CMHT, CRHT, PLS & Ward MHAA referrals should be accompanied by a medical recommendation if a joint MHA s not possible, submitted through Thalamos - completed by an appropriate clinician

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| AMHP Service | |  | |  |  | |
| AMHP Service | 01234 893867  *Mon-Thurs: 9am–5pm*  *Fri: 9am–4:30pm* | AMHP 1  07748 106264 | | AMHP 2  07748 123665 | [elft.amhpservice.bedfordshire-luton@nhs.net](mailto:elft.amhpservice.bedfordshire-luton@nhs.net) | |
| EDT - Out of Hours | 0300 300 8123  *Mon-Thurs: 5pm-9am*  *Fri-Mon: 4pm–9am*  *Public Holidays: 24 hours* | | | For referrals, which cannot wait until the AMHP Desk, is operational. | [edt@centralbedfordshire.gov.uk](mailto:edt@centralbedfordshire.gov.uk) | |
| Referral Information | | |  | | | |
| **Date and Time Referral sent:** | | |  | | | |
| **Service User Name:** | | | **Date of Birth:** | | | **Age:** |
| **Address:** | | | **NHS Number:** | | | |
| **Telephone No:** | | | **GP Details:** | | | |
| **Care Co-ordinator / Mental Health Team Details:** | | | **Persons current location;** | | | |
| **Family Contact Details (inc Nearest Relative):** | | | **Communication Needs (Interpreter required, sign language, deaf or Blind, Flash cards etc.)** | | | |
| **Have Least restrictive alternatives been considered; Crisis Home Treatment Team(CRHTT); Support from**  **Family and social networks; Informal admission? If not explored please detail why.** | | | | | | |

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| **Referrer Name:** |  |
| **Role:** |  |
| **Organisation:** |  |
| **Contact Number:** |  |
| **Email:** |  |
| **Responsible Clinician:** |  |
| **If referrer not available, nominated person to discuss referral;** |  |

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| **EDT Referrals:**  **Is this referral urgent, can the referral wait until the AMHP Duty Desk is Operational, please provide a rationale for out of hours assessment** *(please note- all non-urgent routine referrals should be sent directly to AMHP Service and not EDT)* | |  | | | |
| **What is the outcome of the Mental Capacity Assessment?** (*Has capacity been assumed? What support has been provided to maximise decision-making (distractions, communication needs, support given).* | | | | | |
| **Rationale for MHAA Request: Current concerns** (Describe presenting symptoms- mood-low-mania, delirium, unusual behaviours, visual, auditory, olfactory hallucinations, paranoia, delusions, suicidal ideation; non-concordance and non-engagement; crisis etc.) | | | | | |
| Risk Assessment |  | |  |  |
| Current Risk concerns (Describe risks to health and safety- To self; to others and from others) DESCRIBE | | | | | |
| Historical Risks: | | | | | |
| **What is the contingency plan in place – how will you support until the MHAA referral is considered under s13 MHA 83; completed if required? Contact made with emergency services if deemed necessary.** | | | | | |
| Safeguarding concerns for Service User (or others)? | *Please provide details here: -* | | | | |
| Is the person medically fit for MHAA? | *Please provide details here: -* | | | | |
| Date last seen / assessed by Doctor or other Health Care Professional? | *Please provide details here: -* | | | | |
| Medical recommendation made? (Doctor / RC)  If not completed would the RC be available for a joint assessment | Yes / No\*. *If yes, please provide details here: - Please submitted through Thalamos system.* | | | | |
| Are there any likely access issues?  **Home ownership status**  Housing details/ owned, private rent, housing association or council owned | *Please provide details here: -* | | | | |
| Carer responsibility (children / other)? | *Please provide details here: -* | | | | |
| Pets care issues? | *Please provide details here: -* | | | | |

*\* Delete as appropriate*

**Please note, the referral cannot be allocated to an AMHP until all the information is provided within the referral form.**

Review & Decision Making

*Note: All referrals actioned by AMHP Candidate will have professional oversight by an approved AMHP*

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| Details | |  |  |  |
| To be completed by AMHP / EDT Lead | **Date and Time of Review:** | **Name & Role of Reviewer:** | | | |
| **Outcome of Reviewer:** | **Name of AMHP allocated to give referral further consideration on behalf of the Local Authority - *in line with Section 13(1) of the MHA*:** | | | |
| **Rationale for Review Decision:** | | | | |

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| To be completed by the AMHP Professional | Review decision feedback given verbally to the referrer | Yes / No | Name of AMHP giving feedback: |  |
| Name of person receiving feedback: |  |
| Date & Time of feedback given: |  | | |
| Reviewer decision feedback given in writing to the referrer | Yes / No | Name of AMHP giving feedback: |  |
| Name of person receiving feedback: |  |
| Date & Time of feedback given: |  | | |
| Details of plan and signposting advice, if MHAA not indicated:  Name of AMHP / EDT Lead the plan has been discussed with: |  | | |
| Escalation process triggered if review decision queried? | Yes / No\* |  | |

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| Names of those involved in escalation process | |
| AMHP / EDT Officer | ELFT Manager/ ELFT Operational Manager / EDT on-call Manage/ EDT Team Manager/ EDT Service Manager |
|  |  |
| Overall outcome of Referral: |  |

**Following completion of an MHA, please complete the following checklist:**

AMHP brief report completed and uploaded

Legal paperwork submitted to Law office and ward/ AMHP inbox

Medical rational completed and uploaded, where applicable

Rio entry completed - Day AMHP service

Diary Entry – Day AMHP service

DRMD completed and uploaded -