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 must be accompanied by a medical recommendation - completed by an appropriate clinician

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| AMHP Service | |  | | |  | |  | | | | |
| AMHP Service | 01234 315706  *Mon-Thurs: 9am–5pm*  *Fri: 9am–4:30pm* | AMHP 1  07748 106264 | | | AMHP 2  07748 123665 | | elft.amhpbedford@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 | | | | |
| Referral Information | | | |  | |  | | |  |
| **Date and Time Referral sent:** | | | | **Referrer Name:** | | | | | | |
| **Role:** | | | | | | |
| **Organisation:** | | | | | | |
| **Contact Number:** | | | | | | |
| **Email:** | | | | | | |
| **Responsible Clinician:** | | | | | | |
| **If referrer not available, nominated person to discuss referral;** | | | | | | |
| **EDT Referrals:**  **Is this referral urgent can the referral wait until the AMHP Duty Desk is Operational, rationale for out of hours assessment** *(please note- all non-urgent routine referrals should be sent directly to AMHP Service and not EDT)***.** | | | |  | | | | | | |
| **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?** | | | | | | | | | | |
| **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) | | | | | | | | | | |
| 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?  If not completed would the RC be available for a joint assessment | | | Yes / No\*. *If yes, please provide details here: -* | | | | | | | |
| Location of medical recommendation, if completed? | | | *Please provide details here: -* | | | | | | | |
| Are there any likely access issues? | | | *Please provide details here: -* | | | | | | | |
| Carer responsibility (children / other)? | | | *Please provide details here: -* | | | | | | | |
| Pet 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: |  | |