

**All Saints Hospital**  
 C/o St George Health Care Group  
 Floyd Drive, Warrington, WA2 8DB  
 Tel: 01925 423300 Fax: 01925 576752  
**DEAF SERVICE REFERRAL FORM**



*\* Please complete all information requested*

<b>DEAF SERVICE REFERRAL</b>		<b>PATIENT INFORMATION</b>	
Patient Referred By:		Name:	
Name:		DOB:	
Position/Post:		Current Address:	
Address:		NI no:	
		NHS no:	
		MHA Health Status:	
Tel:		Religion:	
Email:		Nearest Relative:	
Date Referred:		Address:	
Ethnic Origin:			

<b>REASON FOR REFERRAL (Brief Background Details)</b>

<b>FUNDING AUTHORITY:</b>	<b>OTHER AGENCIES INVOLVED:</b>
PCT Address:	GP:
	Address:
Key Contact Name:	<b>RMO DETAILS:</b>
Address:	Name:
	Position:
Tel:	Address:
Email:	
<b>SECURE COMMISSIONING DETAILS:</b>	Tel No:
Name:	Email:
Address:	<b>CARE CO-ORDINATOR:</b>
	Name:
Tel:	Address:
Email:	Tel:

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	Email:
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<b>Cause of Deafness (if known)</b>
<b>Communication:</b> Please indicate below the preferred method of communication and fluency.
<b>Physical Health:</b>
<b>Mental Health:</b>
<b>Current Treatment/Therapies:</b>
<b>Medication:</b>
<b>Ability to Learn New Strategies:</b>
<b>Other Information:</b>

<b>SOCIAL BACKGROUND – FAMILY INFORMATION:</b>			
<b>Significant Family Contact:</b>		<b>Marital Status:</b>	
<b>Brief Social Circumstances:</b>			
<b>Previous Hospitalisations, Residential Placements, Prison Placements:</b>			

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**PRESENTING INFORMATION DETAILS:**

*Please indicate the patients presentation in respect of the areas identified below. This will assist with our Pre-Admission assessment process.*

<b>Communication (Expressive and Receptive):</b>
<b>Attention/Concentration/Memory:</b>
<b>Orientation:</b>
<b>Cognitive Impairment:</b>
<b>Behavioural/Emotional Issues:</b>
<b>Daily Living/Personal Care:</b>

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**On-going Medical Health Issues:**

**Mental Health and Legal Classification of Mental Disorder:**

**Substance Misuse:**

**Mobility Issues:**

**Current Management Plan (if applicable):**

**Any other Information:**

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<b>INITIAL RISK ASSESSMENT SCREEN: <i>Please circle or strikethrough</i></b>						
<b>CURRENT</b>	<b>Yes</b>	<b>No</b>	Deliberate Self Harm/Attempted Suicide	<b>PAST</b>	<b>Yes</b>	<b>No</b>
<b>CURRENT</b>	<b>Yes</b>	<b>No</b>	Acts of direct self harm	<b>PAST</b>	<b>Yes</b>	<b>No</b>
<b>CURRENT</b>	<b>Yes</b>	<b>No</b>	Alcohol/substance misuse	<b>PAST</b>	<b>Yes</b>	<b>No</b>
<b>CURRENT</b>	<b>Yes</b>	<b>No</b>	Suicidal Ideation	<b>PAST</b>	<b>Yes</b>	<b>No</b>
<b>CURRENT</b>	<b>Yes</b>	<b>No</b>	Mental Health Issues/Illness	<b>PAST</b>	<b>Yes</b>	<b>No</b>
<b>CURRENT</b>	<b>Yes</b>	<b>No</b>	Violence, destructive behaviour to objects	<b>PAST</b>	<b>Yes</b>	<b>No</b>
<b>CURRENT</b>	<b>Yes</b>	<b>No</b>	Violence, aggression to other patients	<b>PAST</b>	<b>Yes</b>	<b>No</b>
<b>CURRENT</b>	<b>Yes</b>	<b>No</b>	Violence, aggression to staff	<b>PAST</b>	<b>Yes</b>	<b>No</b>
<b>CURRENT</b>	<b>Yes</b>	<b>No</b>	Serious Self Neglect	<b>PAST</b>	<b>Yes</b>	<b>No</b>
<b>CURRENT</b>	<b>Yes</b>	<b>No</b>	Medication Compliance Issues	<b>PAST</b>	<b>Yes</b>	<b>No</b>
<b>CURRENT</b>	<b>Yes</b>	<b>No</b>	Exploitation of Others	<b>PAST</b>	<b>Yes</b>	<b>No</b>
<b>CURRENT</b>	<b>Yes</b>	<b>No</b>	Vulnerability to Others	<b>PAST</b>	<b>Yes</b>	<b>No</b>
<b>CURRENT</b>	<b>Yes</b>	<b>No</b>	Disinhibited Unsocial behaviour	<b>PAST</b>	<b>Yes</b>	<b>No</b>
<b>CURRENT</b>	<b>Yes</b>	<b>No</b>	Impulsive Behaviour	<b>PAST</b>	<b>Yes</b>	<b>No</b>

Signed: .....

Dated: .....

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**FORENSIC HISTORY DETAILS**

Is there a Forensic History resulting in criminal convictions? <i>Please circle or strikethrough</i>	Yes	No
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Please list details below:		
Offence(s)	Date Sentenced	Sentence

<b>Other Offence Related Information:</b>

<b>Details of any Previous Secure Placement:</b>

<b>Details of Current Risk Management Plan</b>