Patient Name…………………………………………………………..

Date of referral………………………………………………………

Inpatient referral form

Before completing this form, please contact our admissions team for the latest bed availability and process guidance. When advised to do so, please complete this form, save as, and then send us an email attachment with accompanying information directly to acute.referrals@groveparkhealthcare.co.uk

Admissions Team	
Available Monday-Friday 8:30am – 5:30pm	Telephone: 01273 543 570
Monday to Thursday – last admission accepted at 8pm. **Email**:acute.referrals@groveparkhealthcare.co.uk	

Patient Details	
Name:	Patient diagnosis:
NHS Number:	Current placement:
Gender:	Date of birth:
First language:	Ethnicity:
Patient's Home Address & Telephone No:	
Religion:	Specific communication considerations:
Current placement / Contact Name: Telephone No:	Date of admission to current placement:
Legal status	Date of detention

Important Contact Details	
Next of Kin / Guardian – Full Name:	Telephone:
Current Responsible Clinician Name:	Telephone:
GP Name & Surgery:	Telephone:
Care Co-ordinator Name/ Community Team Name:	Telephone:
Social Worker Name:	Telephone:
Bed Manager Name:	Telephone:

Grove Park
Healthcare Group

Reason for referral
Please provide your reason for referring this patient and what specific outcomes you are looking for:
To allow us to make a clinical decision please aim to provide the following patient information:

Background history
Psychiatric history
Medical history (inc. allergies and drug reaction)
Drug and alcohol history
Full Section paperwork
Current medication and care provided
Social history, inc. current significant relationships
Risk history
Physical health and mobility needs

This information can be supplied by sending the following patient documents with this referral form. Please tick the information you have included:

- ☐ Psychiatric report
- ☐ Patient Risk Assessment including risk/incident logs
- ☐ Manager's hearing report – Psychiatric and Social Work
- ☐ Mental Health Tribunal report – Psychiatric and Social Work
- ☐ Gatekeeping assessment
- ☐ Section Paperwork
- ☐ Discharge summaries
- ☐ List of current medications inc. PRN
- ☐ Current care plan
- ☐ Forensic summary
- ☐ CPA reports

Please detail any other information available which could help us to make a clinical decision.

Referrer Details	
Referrer Full Name:	Telephone:
Organisation Name:	Email:
Authorisation/Commissioning Details	
Organisation responsible for funding	
Telephone:	Email:
I confirm that I have the delegated authority to authorise this episode of treatment on behalf of the funding authority. I understand and agree that all accepted referrals would be subject to Grove Park Healthcare Inpatient Terms in force during the patient's inpatient stay. The current version of these terms is available at www.groveparkhealthcare.co.uk	
Name:	Digital signature:
Telephone:	
Please note: For all admissions, we will also require a signed Named Patient Agreement, which will be sent to you from our Admissions team. Enhanced support or escorted nursing is not included in the daily bed rate. For these fees, please contact our Admissions team on 01273 543 570	

Thank you for your referral. Please email all information to our admissions team who will contact you shortly.