Wigan Council

5 Boroughs Partnership NHS
NHS Trust

Crisis Resolution and Home Treatment Team Referral Form

(for people aged 16 to 65th birthday)

About the person being referred.

(Please give as much information as possible.)

Title (Mr/Mrs/Ms/Miss): _____ Surname: _____

Forename: _____ Alias (if any): _____

Other ID/Index No: _____ Episode No: _____

NHS No: _____ Date of birth: _____

Current address: _____

_____ Postcode: _____

Phone number: _____ Gender: ☐ Male ☐ Female

Marital status: _____ PAS Code: _____

Previous address: _____

Religion: _____ Ethnic group: _____

About their next of kin.

Name: _____

Address: _____

_____ Phone No: _____

Relationship to person being referred: _____

About their doctor.

GP's name: _____

Address: _____

_____ Phone No: _____

About their problems.

Brief description of problem(s).

Current psychiatric symptoms.

About their problems (cont'd).

Past psychiatric history (including information of treatment by doctor).

Any contributory factors (e.g. alcohol, substance misuse, etc.)

Physical illness, including current medication.

Risk of harm to self, including self-neglect.

Has there been a recent attempt of self-harm in the last 6 months?

☐ Yes (please give details below)

☐ No

Is there a history of self-harm?

☐ Yes (please give details below)

☐ No

If yes, was the attempt planned?

☐ Yes (please give details below)

☐ No

Are there thoughts of self-harm?

☐ Yes (please give details below)

☐ No

If yes, what prevented them acting upon these thoughts?

How do they feel now thoughts have been spoken of?

Risk to others, including children.

Have they stated they want to harm others?

☐ Yes (please state who and why below)

☐ No

Forensic history/details.

Is there a risk to children (e.g. neglect, emotional deprivation, physical or sexual abuse)?

☐ Yes (please give details below)

☐ No

Is there any risk to staff?

☐ Yes (please give details below)

☐ No

Additional information (if any).

About the person making the referral.

Your name (IN CAPITALS): _____

Your designation: _____

Your signature (if posting or faxing this form): _____

Date of referral: _____ Time: _____

Is the person you are referring aware that a referral is being made?

☐ Yes
☐ No

Please Note:
The Crisis Resolution and Home Treatment Team only accepts referrals for people aged 16 to 65th birthday. Please fax this referral form to the Crisis Resolution and Home Treatment Team on 01942 264340. Or, return it in an envelope marked CONFIDENTIAL to:

The Crisis Resolution and Home Treatment Team
Hazelmere Unit
Leigh Infirmary
The Avenue
Leigh
Lancs WN7 1HS.

You can also e-mail it to: **accessteam@wiganmbc.gov.uk**

For referrals for people over 65, please contact the Central Duty Team on 01942 828777. Or, fax this form to them on 01942 828790.

This page is for use by the Crisis Resolution and Home Treatment Team only.

Referral accepted, prioritised and allocated:	Reason for decision
Emergency (6 hour)	
Urgent (3 day)	
Routine (7 day)	
Advisory service	
CMHT (please state which)	
Counselling	
GP/Health visitor	
GP/Practice counselling service	
In-patient admission	
Learning disability	
Mentally disordered offenders	
Other local authority	
Substance misuse service	
No further action	
Referral not accepted but redirected (please give reason):	
Screened by:	Date: