**Mental Health Act Assessment – Referral Information Required by Gateway to Care**

Information below to be passed to Gateway to Care for allocation or assessment to AMHP

Where possible please email referrals to

Gatewaytocare@calderdale.gov.uk

Email subject line should read **Mental Health Act Assessment**

**PLEASE COMPLETE WITH AS MUCH DETAIL AS POSSIBLE**

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| --- | --- |
| **Name** |  |
| **Home Address** |  |
| **Date of Birth** |  |
| **GP Details**  |  |
| **Family Contact/Next of Kin/Nearest Relative Details:** |  |
| **Person Known to SWYPFT/AHSC?**Is the service user known to SWYPFT (South West Yorkshire Partnership NHS Foundation Trust) or AHSC? Gateway to Care will identify whether they are known to AHSC.If known, include RiO number, team and name of Care Coordinator |  |
| **Current status under the MHA 1983?**(eg. None / Informal / s5(2) / s2 / s136) |  |
| **What is required?**Normally this will be a request for a MHA assessment. |  |

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| **Current presentation?** |  |
| **Where is the person?**Where is the person currently? This may be ‘Elsewhere’, ‘Home/Community’, or ‘Hospital’ or alternative location. |  |
| **Name of Psychiatrist** |  |
| **Is a Psychiatric Assessment available?**Has a psychiatric assessment been completed and is it available?Has a medical recommendation been completed, if so by whom and where is the paperwork? |  |
| **Other Professional assessment available?** Has any other form of professional assessment been undertaken and is it available? |  |
| **Is the person medically stable?** |  |
| **Is this an urgent referral?** |  |

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| **Risk to Self? / Please detail** |  |
| **Risk to Others?/ Please detail** |  |
| **Risk from Others?/ Please detail** |  |
| **Risk to Staff?/ Please detail** |  |

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| --- | --- |
| **Details of person making referral** (including current telephone number) |  |
| **Details of contact person for out of hours assessment**(for example, this could be a professional or a relative who is available at the time the assessment is likely to take place) |  |
| **Date & Time of Referral** |  |