

GARDAI GP REFERRAL FORM – Send to Local ACUTE MENTAL HEALTH UNIT

Date:
Name:
Address:
Date of birth:
Contact Number:

<u>Garda GP name:</u>
<u>Garda station address:</u>

Please complete option 1 or 2 below:

1. The patient requires assessment in the mental health unit:

A voluntary patient, presenting for a voluntary assessment.

OR

The patient is detained under the Mental Health Act.

Form 3 – verified by psychiatry NCHD at the relevant mental health unit.

AND

Form 5 – verified by psychiatry NCHD at the relevant mental health unit.

2. The patient requires assessment in the emergency department:

A voluntary patient, presenting for a voluntary assessment.

OR

Doctrine of necessity –patient lacks capacity, is medically unwell & presents with urgent/acute risk.

Details of current presentation requiring transfer to an acute hospital setting?:

Details of presentation requiring detention under Mental Health Act Sec. 12 by Gardai?:

If yes to any of the following, please provide details

Risk of self-harm:	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Risk of harm to others:	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Currently under the influence of substances:	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Self-harm/overdose requiring medical treatment:	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Other risks:	Y <input type="checkbox"/> N <input type="checkbox"/>	_____

Name of referrer: _____ **Signature:** _____ **Date:** _____