St Johns Hospital
Old Age Psychiatry (Liaison)
Referral Form

Date of referral: _____

Patient Details (or label)

Name: _____

Address: _____

_____

_____

CHI: _____

GP Practice: _____

_____

Referrer's details

Ward No: _____

Referrer name & designation:

_____

Bleep/Extension: _____

Consultant name: _____

Next of Kin (name & tel no): _____

Date of admission: _____ **Anticipated discharge date**: _____

Reason for admission:

Reason for referral: *(if assessment of capacity, please see separate capacity referral form found on intranet.)*

Current treatment/investigation plan:

Relevant investigations since admission: Blood Test, MSU, Chest x-ray, CT head, other:

Other professionals involved:

Desired outcome: Telephone advice ☐

Ward review ☐

Outpatient assessment (please request only at point of discharg ☐

N.B. routine dementia diagnosis is usually better assessed as an outpatient

*Urgent same day assessments should be discussed with the Old Age Consultant over the telephone. (Old Age secretaries ext. 53786 or via switchboard.)

*Capacity assessments are carried out by Old Age Psychiatrist ***ONLY*** when the treating clinician has assessed and unable to come to a conclusion. Please use separate capacity referral form .

THIS FORM IS ONLY TO USED FOR REFERRALS OF PATIENTS IN ST JOHNS HOSPITAL

Please email this form to OPD5.MentalHealthAppointments@nhslothian.scot.nhs.uk
('*MentalHealthAppointments,OPD5*' *in Global Address List).*
Please note we only accept email referrals now as there have been delays in receiving hand delivered referrals.