





Referral



reason for referral	
Provisional Diagnosis / Presenting Complaint* <input type="text"/> 	
* Please ensure that Urgency is set to SOON or URGENT if required	
Urgency* <input type="text" value="Routine"/>	Priority Reason <input type="text"/>
Mental Health Risk Factors	
Suicide risk <input type="text" value="Not Known"/>	Details <input type="text"/>
Risk of Harm to others <input type="text" value="Not Known"/>	Details <input type="text"/>
Risk of Harm from others <input type="text" value="Not Known"/>	Details <input type="text"/>
Risk to children <input type="text" value="Not Known"/>	Details <input type="text"/>
Any Forensic History <input type="text" value="Not Known"/>	Details <input type="text"/>
Social/Psychological stress factors <input type="text" value="Not Known"/>	Details <input type="text"/>
Client consented to referral <input type="text" value="Not known"/>	Other Agencies Involved <input type="text"/>
Other Information	
Length of History (months/weeks/days) <input type="text"/>	
Additional Comments <input type="text"/>	
Transport and Clinic Information	
Transport required <input type="text" value="No"/>	Transport details <input type="text"/>
Referring Clinic Location* <input type="text" value="Select from the drop down list"/>	

Past Medical History




Pre-existing Conditions (Medium and High priority)				
Condition Name	Laterality	Modifier	Extension	Date of Onset
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>  




Past Procedures (Medium and High priority)			
Procedure Name	Laterality	Modifier	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>  

Family History

Family Conditions (High priority)				
Condition Name	Modifier	Extension	Relation to Patient	Recorded Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>  

Medication


Current Medication (Active and issued within the last 12 months)						
Drug Code	Drug Name	Preparation	Dose	Frequency	Started	Due to complete
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> 	<input type="text"/>  

Other Medication (Issued within last 90 days)						
Drug Code	Drug Name	Preparation	Dose	Frequency	Started	Completed
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> 	<input type="text"/>  

Clinical Warnings

Lifestyle Risks - General Information	
Weight (kg) <input type="text"/>	Height (m) <input type="text"/>
BMI (Weight / Height) <input type="text"/>	Blood Pressure (Systolic) <input type="text"/> Blood Pressure (Diastolic) <input type="text"/>
Lifestyle Risks - Smoking	
Smoking Current Status <input type="text" value="(Not Known)"/>	<input type="button" value="Add Row"/>
Smoking history - recorded through screening <input type="text"/>	Date recorded <input type="text"/> <input type="button" value="X"/>
Smoking history - recorded through Encounters <input type="text"/>	Date Recorded <input type="text"/> <input type="button" value="X"/>
Lifestyle Risks - Alcohol	
Alcohol Current Status <input type="text" value="(Not Known)"/>	<input type="button" value="Add Row"/>
Alcohol history - recorded through Screening <input type="text"/>	Date recorded <input type="text"/> <input type="button" value="X"/>
Alcohol history - recorded through Encounters <input type="text"/>	Date Recorded <input type="text"/> <input type="button" value="X"/>
Exercise	
Exercise Status <input type="text" value="(Not Known)"/>	Non-Therapeutic Drugs <input type="text"/>
Allergies	
Description <input type="text"/>	Recorded <input type="text"/> <input type="button" value="X"/>
Intolerances	
Description <input type="text"/>	Recorded <input type="text"/> <input type="button" value="X"/>
Risk To Others	
Description <input type="text"/>	Recorded <input type="text"/> <input type="button" value="X"/>

Demographics

Patient Details	
Title* <input type="text"/>	Forename* <input type="text"/>
Surname* <input type="text"/>	Previous Surname <input type="text"/>
Address* <input type="text"/>	
Post Code* <input type="text"/>	Health Board <input type="text" value="Dumfries and Galloway"/>
Phone Number <input type="text"/>	Email Address <input type="text"/>
Date of Birth* <input type="text"/> 	CHI Number <input type="text"/>
Sex* <input type="radio"/> Male <input type="radio"/> Female	Marital Status <input type="text" value="Not Known"/>
Background Data	
Housing <input type="text"/> ?	Employment <input type="text"/> ?
Religion <input type="text"/> ?	Ethnic Origin <input type="text"/> ?
Language <input type="text"/> ?	Religious Observance <input type="text"/> ?

Administration

Referral Classification		
Date of Referral*	05-Oct-2007	
Nature of Request*	Not Specified	
Referring GP		
GP Practice	Nithbank (18305)	
GP		
Name*		
GMC Code*		
GP Code		
Practice Code*		
Practice Name		
Phone Number		
Fax Number		
Address		
Referral To		
Hospital Name*	Annandale and Eskdale LHP	
Hospital Address	Virtual location code - SCI Gateway	
Hospital Phone Number		
Specialty*	General Psychiatry (Mental Illness)	
Protocol*	DG-D CMHT	
Consultant		
Consultant Surname		
Consultant Forename		
Consultant Grade	Consultant	
Administrative Information		
Patient will accept any doctor <input type="checkbox"/>	Patient will accept any site <input type="checkbox"/>	
Patient will accept cancellation or short notice appointment <input type="checkbox"/>	Patient has disability or requires wheelchair access <input type="checkbox"/>	
Administration Alerts		
	Description	Recorded Date
Visual Impairment		
Impaired Hearing		