Bloomfield Hospital Referral Form 2023

General Details

Last Name:	**First Name:**	**D.O.B:**
Gender:	**Marital Status:**	**No.of Children:** **No of Children:**
Home/Permanent Address: **Contact Number**: **Is the service user currently residing in a psychiatric/ medical unit : Yes☐ No☐** *If yes, please give address:* **Length of stay in acute unit:**		

GP Details:	**Name:** **Address:** **Contact No**.
Community Pharmacy details:	**Name:** **Address:** **Contact No.**
Community Mental Health Team details:	**Name:** **Address:** **Contact No.**

Consultant Details:	**Name:** **Address:** **Contact No**. **Email Address:**
Referrers Contact Details:*:	**Name:** **Address:** **Discipline:** **Contact Mobile No:** **Email Address:** *** *NB*** *Must be a nominated healthcare professional from the community mental health team (CMHT) or referring team. Their role involves managing the Bloomfield referral and transfers. They are the main point of contact between Bloomfield MDT and referring team. months)*
Next of Kin Details:	**Name**: **Relationship:** **Address:** **Contact No:** **Is the next of kin aware of referral to Bloomfield? : Yes ☐ No☐**
Legal Status:	**Is the service user detained under the Mental Health Act?** **Yes ☐ No ☐** *If yes for how long?* **Is the service user Ward of Court? Yes ☐ No ☐** **Does the service user have any recent court judgements or court orders in place? Yes ☐ No ☐** *If yes, please give details*

End of Life Care/ Resus Status	**Is the service user for full resuscitation? Yes ☐ No ☐** **Is there an advanced healthcare directive/ plan ? Yes ☐ No ☐** **Has the treating team discussed end of life management with service users family? Yes ☐ No ☐** **If not – why not ?** **(Huntington's disease) Has team discussed PEG Feeding with family/service user ? Yes ☐ No ☐** **Please include SALT & Dietician Assessments**
Vaccination Status	**Has service user received Covid vaccination/ booster? Yes ☐ No ☐ or Refused ☐** **Has the service user had Covid in the past 6 months? Yes ☐ No ☐** **When did they last receive the booster?**

Medical Card No: **Expiry Date:**	**PPS No:**
Source of Income:	**Public Services Card: Yes ☐ No ☐**

Reason for referral to Bloomfield Hospital

*N.B. Please refer to **Inclusion** and **Exclusion** Criteria for referral to Bloomfield as outlined below. Only complete the referral form if service user's clinical presentation fits the inclusion criteria.*

Inclusion Criteria:	**Exclusion Criteria:**
• People defined as having severe and enduring illness with behavioural or psychiatric issues due to Neurodegenerative illness/ Functional Mental illness whose needs are not adequately met by the sector of services and who fulfil the following criteria: • Ongoing symptoms (e.g. hallucinations, delusions, high levels of anxiety or depressions, negative symptoms of psychosis) • Reduced social functions (e.g. breakdown of social relationships, reduction in the capacity for economic support)	• Acutely unwell because of their mental illness • Medically unwell, high medical needs or medical instability to a degree that cannot safely be managed within a hospital such as Bloomfield • Those who require a low secure setting • Those that require access to seclusion room • Those who require a PICU placement or behavioural difficulties to a degree that cannot be safely managed within Bloomfield Hospital

Brief Account of Reasons for Referral (including diagnosis)

Professionals Assessment Report Guidelines Section

Guidelines for Case Report

A full case report should be forwarded with each referral. Given the specialised nature of the service it is important to include the information outlined below in the case report.

- **Current Admission:** *Please include background to/circumstances of current admission.*
- **Progress in Hospital**
- **Past Psychiatric History***: Please note previous admission, diagnosis, treatments used and response to treatment*
- **Past Medical History:** *Please note previous admission, diagnosis, treatments used and response to treatment*
- **Medications:** *Please include side effects, allergies, sensitivities and adherence. If on depot medication:*
- **Legal Status:**
- **Risk Assessment:** *Please include up to date risk assessment*
- **Personal History:** *Please include Early Life/Education and work record & Psychosexual History/Current Relationships*
- **Family History:** *Please include profile of family; degree of contact with each family member, relationship with family member. History of Mental Illness in family*
- **Social Circumstances:** *e.g. accommodation/Financial*
- **Premorbid Personality**
- **Strengths and areas of potential**
- **Substance Use History**
- **Forensic History:** *Violence, threats, protection or barring orders, treatment in a secure setting or forensic hospital (Ireland or Overseas), sexually motivated criminal act, criminal charges or convictions. Please include forensic report if available*
- **Mental State Examination**
- **Diagnosis ICD 11:**
- **Assessment of care needs: (If assistance is required, level of independence).**

Guidelines for Occupational Therapy Report

Name:
DOB:
Occupational therapist:
Date of assessment:
Reason for assessment:
Techniques for assessment:
Outcome:

Daily Routine (occupational balance)	
Sleep Routine	
Personal Activities of Daily Living (PADLs)	
Basic Activities of Daily Living (BADLs)	
Instrumental Activities of Daily Living (IADLs) *e.g. planning, organizational skills, initiating& completing tasks*	
Leisure Interests	
Work/Education	
Transport	
Social Interaction	
What occupations does the person identify as helping them to manage their mental health difficulties?	
What is the persons hope for their future?	
What are the potential challenges to an admission to Bloomfield Hospital for this service user at this time?	

**It is expected that a standardised assessment of occupational function will be used in completing this assessment.*
***This is not intended to be an exhaustive list and as always the occupational therapist will use his/her clinical reasoning to determine the assessment required.*

Guidelines for Clinical Psychology Report

The Clinical Psychology report should provide a comprehensive psychological assessment and formulation of the service users presenting problems- including history, family background, relationships, strengths and coping skills, previous psychological interventions, if any, current needs and reason for referral to Bloomfield Hospital. Where possible - particularly for patients with neurodegenerative conditions, it would also include the results of a recent neuropsychological assessment (see Appendix) Please also include any previously completed psychology and forensic reports and/ or results of previous neuropsychological assessments which may guide intervention with this person.

Name:
DOB:
Dates of Assessment/Report:
Presentation:
Presenting Problem:
History of Presenting Problem:
Background History: (to include attachment and relationship history)
Educational & Occupational History:
Risk issues: (present and past, including forensic history, if any)
Strengths:
Assessment techniques/tools and rationale:
Assessment results:
Psychological formulation: (to include, if possible, understanding of complex needs)
Previous psychological interventions, if any:
Current needs:
Service user's view of needs:
Recommendations:

It is a given that these units are designed for people with complex needs. However, it would be helpful to flag potential challenges to a successful placement at this point, in order to plan for these possibilities. Can you identify any potential challenges to a successful placement in Bloomfield Hospital? Any recommendation to mitigate these challenges?

Appendix
Potential Psychometric Assessment Tools
An assessment battery may include:

- Test of Pre-morbid Functioning (TOPF)
- Wechsler Abbreviated Scale of Intelligence-II (WASI-II)
- Wechsler Adult Intelligence Scale-IV (WAIS-IV)
- Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)
- Behavioural Assessment of Dysexecutive Syndrome (BADS)
- The Dysexecutive Function Questionnaire (DEX)
- Addenbrooke – III (ACE-III)
- Wechsler Memory Scale (WMS)
- Test of Non-Verbal Intelligence (TONI)
- Beck Depression Inventory (BDI)

- Delis-Kaplan Executive Function System (or subtests from it)

This list is not intended to be either a) directive or b) exhaustive. The Clinical Psychologist will use her/ his clinical reasoning to determine the assessment required. Please include any other appropriate assessment tools, assessment findings and recommendations.

Guidelines for Social Work Report

The Social Work Report should provide a comprehensive psychosocial assessment of the service user needs as per standard social work practice. It should highlight the current needs of the service user in all the key areas of their life, the social workers level of contact and key interventions to date and the reason for referral to Bloomfield Hospital. This guideline is intended as guidance only and should not be considered exhaustive. The social worker should use their professional judgement to determine the content of the report as appropriate to the referral.

It would be helpful that the report pay particular attention to the following key areas;

- **Accommodation:** *include an accommodation history, current living situation, previous residential placements, potential for independent living/ independent living skills, supports needed to maintain accommodation, reason for referral to the placement in Bloomfield Hospital.*

- **Mental Health:**_ *include a mental health history and a description of current mental health difficulties, significant lift events, history of abuse/trauma, and a summary of any complex needs.*

- **Service User's views**: *include the service user's views in their care plan and their mental health needs, their plans and hopes for the future, their views on a potential move to Bloomfield, their strengths and resilience and support network.*

- **Family/Carers/ Supporters Views**: *include their views on the care plan, views on a move to a placement in Bloomfield, the proposed post discharge plan and their own support needs.*

- **Risk/ Safeguarding Issues***: identify current risk factors, vulnerabilities and protective factors, safeguarding issues and safeguards in place*.

- Financial issues:

Guidelines for Nursing Assessment Report

The Nursing Report should include:

1. A copy of the current Nursing Care Plan
2. A Nursing summary of the patient's in-patient nursing care / history
3. A Community Mental Health Nurse Summary :if available)
4. The report **MUST** mention the following:
    1. Type of diet- Normal diet/ special diet
    2. Type of fluid – Normal fluid/ thickened fluid
    3. Mobility status
    4. Ability to communicate
    5. Compliance to medication

Service User & Family Members

Is the service user aware of the referral? Yes ☐ No ☐
If not please give reason

Is the NOK aware of the referral? Yes ☐ No ☐
If not please give reason

Service User information

At Bloomfield Hospital You and your team will develop a treatment plan together that will support you towards reaching your goals. The team will offer you support in a place that is designed to assist your recovery.

Visiting
Friends and family are very welcome. You can let staff know who you choose to visit you during your stay.

Service Users View :

(Please state in your own words your individual needs and personal goals that you would like to address)

Consent, Agreement & Confidentiality

(*Consent forms are important –Please ensure there is an initial beside each statement and a final signature and date at the end of the consent form. Please ensure in the event of a service user being unable to give consent a capacity assessment is documented).*

- I give permission to _____(Name of referring agent) to include **my personal and health information** in this form named Referral Form to Bloomfield Hospital) **YES** ☐ **NO**☐
- I understand that this form must be completed so that the staff in Bloomfield Hospital can understand my individual case **YES** ☐ **NO** ☐
- I would like to be considered for a place in Bloomfield Hospital **YES** ☐ **NO**☐
- If offered a place in Bloomfield Hospital I will work with the staff on my care plan **YES** ☐ **NO**☐
- I understand that my personal and clinical information is shared between the staff in Bloomfield Hospital and the coordinator of my care in my local area **YES** ☐ **NO**

Name:_____Signature:_____

Date:_____

If the service user cannot provide consent please clearly state the reasons why

(Include capacity assessment)

Family/ Friends/ Carer

Checklist and Signatures of Referring Agent and Head of Service

I/ We hereby declare that all information and reports of material relevance to the assessment of _____ for admission to Bloomfield Hospital have been divulged to the assessors.

I/We understand that any information previously available to the referrer, which comes to light after the admission and which was withheld from the assessment process and which would have had a bearing on that admission may result in the discharge of the person concerned

Signed _____ Date _____

Consultant Psychiatrist

On behalf of HSE Area

Referring Agent :

Name:_____
Job Title:_____
Signature:_____
Date: _____

Checklists for Referral:

Referral Form:▫
Psychiatric Case Report ▫
Risk assessment ▫
OT Report: ▫
Speech Therapy Report that mentions swallowing and service users attitude to PEG▫
Dietician Report ▫ (esp for HD patients)
Psychology Report: ▫
Social Work Report: ▫
Nursing Report : ▫
Copy of up to Date Individual Care Plan:▫
Other Relevant Reports: ▫

Checklist to be completed by Head of Service
(This has to be signed by Heads of Service or nominee prior to referral being sent. Please note if this section is not completed referrals will not be accepted)

Does the CHO agree for the service user to be readmitted to their services again in the event of a failed placement at Bloomfield Hospital:

Yes ☐ **No** ☐

If the event of the Bloomfield Hospital placement not being successful, do you agree to provide a placement for service user? **Yes** ☐ **No** ☐

Name: _____

Signature: _____

Please provide stamp from Head of Service Office

NB. Please return completed form with appropriate reports to referrals@bloomfield.ie