

CTO details: (if applicable – include responsible psychiatrist and practitioner, CTO details and key dates)		
Purpose of HITH referral and desired outcomes for admission: (Can include consumer and family member/carer perspectives)		
Details of other services involved or referrals made: (e.g. Community Clinic, GP, NGOs)		
Medical history: (include allergies, current treatments and any physical health requirements)		
Current medications:		
Provided Paperwork: please provide with referral or tick if available		
Not available on PSOLIS: please provide scanned copies with referral of appropriate documents		
<input type="checkbox"/> Mental health assessment	<input type="checkbox"/> Copies of last medical review from clinical notes	
<input type="checkbox"/> Community visiting risk assessment tool	<input type="checkbox"/> Care transfer summary	
<input type="checkbox"/> Recent MSE	<input type="checkbox"/> Recent physical health examination	
Available on PSOLIS, Best Practice or NACs: please tick those which apply but do not send		
<input type="checkbox"/> BRA/RAMP	<input type="checkbox"/> Discharge summary	
<input type="checkbox"/> Current care plan	<input type="checkbox"/> Medication list	
<input type="checkbox"/> Collaborative action plan	<input type="checkbox"/> CTO documents	
<input type="checkbox"/> Recent triage documentation		
<input type="checkbox"/> Other, please list:		
Referrer Details		
Referring clinical service:		
Referrer name:	Designation:	
Contact details:		
Patient active with a mental health clinic?	Y/ N	Clinic:
Treating Doctor:	Case manager:	
Name of referrer:	Signature of referrer:	Date: