ADDRESS
Phone: 0121 5540666 or 0118 9401144
Fax: 0118 9401145
E-mail: info@salvero.co.uk
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REFERRAL FORM

Referrer Details			
Name of Referrer			
Telephone Number		Fax Number	
Status of Referrer		Trust or Hospital	
Funding Authority			

Service User Details			
Name of Service User		Date of Birth	
Ethnicity		Gender	
Nearest Relative		Telephone Number	
Status MHA (1983)		Date Implemented	
Expiry Date		GP	

Details of Referral			
Type of Referral (Please circle one option)	Urgent	Planned	
Immediate problems and risks presented (Please circle all that apply)	Absconsion	Aggression	Arson
	Depression	Non-Compliance	Self-Harm
	Sexually Disinhibited	Suicidal	Unpredictable
	Other (Please Specify):		
Type of service required (Please circle if known)	Aspergers Syndrome / High Functioning Autism	Autism	Borderline Personality Disorder / Self Harm
	Community Rehabilitation / Social Care	Supported Living	Intense Rehabilitation
	Other (Please Specify):		

Additional Information
Please provide an overview of the following and where necessary, fax all relevant documentation along with this referral form:

- Problems and risks which have been identified
- Details of where the Service User is currently placed
- Details of events leading up to the referral and why admission is required

Please indicate how many additional sheets you have faxed with this referral form			
Date of referral		Time of referral	
Signature of referrer			

Completed application forms are to be returned to: