

**BEH Crisis Telephone Service  
URGENT REFERRAL FORM**

*Please use this form for all Barnet, Enfield and Haringey Crisis Telephone Services urgent referrals.  
Please complete and return to the relevant service:*

Referral Date:

Urgent:  (requiring face to face assessment within 24 hours)

**Referral email: [nft.behcrisis.telephonehub@nhs.net](mailto:nft.behcrisis.telephonehub@nhs.net)  
Please call 02087023500 to confirm receipt and for discussion**

**GP Information**

<b>Name:</b>  <b>Surgery:</b>  <b>Address:</b>  <b>Postcode:</b>	<b>Referral Clinicians Contact details:</b> <b>Name:</b> <b>Mobile:</b>  <b>Email:</b>  (Do not provide generic practice contact details)
--	---

**Patient Information**

<b>Name:</b>	<b>Date Of Birth</b> 08-Sep-1999	<b>Male / Female:</b> Female
<b>Current Address</b>	<b>Home Telephone</b>	<b>Mobile No</b> 07758132803
<b>Postcode</b>	<b>Ethnicity</b>	<b>Main Language Spoken</b> Main spoken language
	<b>NHS Number</b>	<b>Interpreter Needed</b> Y/N
<b>Has the person agreed to this referral?</b>  Y/ N	<b>Immigration status</b>	<b>Marital status</b>

**Referral information**

<b>Reason for referral and any relevant Background information:</b> <i>(presenting problem, duration, severity including the nature of mental health concern; any significant family difficulties, bereavement, illness etc.)</i>	
<b>Consultations</b>	
<b>Date</b>	<b>Consultation Text</b>
Problem:	<i>(Review)</i>



History

Comment

Date:	Telephone consultation:
Problem	<i>(Review)</i>

History

Medication

Comment



What are you hoping to achieve by making this referral?

**Brief Risk Summary:**

moderate

**Diagnosis and Current Medication:**

**Problems**

*Active*

Date	Problem	Associated Text	Date
------	---------	-----------------	------

**Medication:**

*Acute:*

Drug	Dosage	Quantity	Last On
------	--------	----------	---------

*Repeat*

Drug	Dosage	Quantity	Last On
------	--------	----------	---------

*Repeat Dispensing*

Drug	Dosage	Quantity	Last On
------	--------	----------	---------



Previous treatment / medication, including any significant physical health history:

Signed: \_\_\_\_\_

Date:

Print name:

Please return this form by email with any supporting documentation:

[nlft.behcrisis.telephonehub@nhs.net](mailto:nlft.behcrisis.telephonehub@nhs.net)

**PATIENT'S REASONABLE ADJUSTMENT INFORMATION**

Patient has an impairment meeting the threshold for a Reasonable Adjustment:

Identify that, having reached the threshold for Reasonable Adjustment, the patient actually needs one:  
N/A