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| **CCG Funded Specialist Placement Request Form for Mental Health** |
| Name of team referring and practitioner: |
| Referral Date: | Time  | NHS Number |
| Name*:* including any previous names/aliases  | Title: |  |
| Address: Post Code:  |
| Telephone Number:Mobile Number: |
| Gender:  | Date of Birth:Age: |
| Does the person have capacity to consent to a specialist placement?  |
| Person’s legal status: |
| GP details, including practice:Tel Number: |
| Reason for referral for specialist placement and treatment required:  |
| What interventions / treatment has the client received, from whom and when? What has been the outcome? |
| What would the service want as an outcome from the placement? |
| Does the service user want to engage in a placement? If not, why not?  |
| What would the service user want to gain from a specialist placement? |
| What treatments are indicated? i.e. Length of time, type, intensity, purpose? Were they evidence based?  |
| Are these available locally? |
| What would be the impact of a specialist placement on any children/dependants/ family unit? |
| Please describe what (if any) specialist placements have previously been provided and comment on their outcomes .i.e. Where was the placement? When did it occur? Duration of placement? Treatment given? Outcomes? Long term impact? |
| Evidence of diagnostics, psychological formulation and client need (Please attach reports from relevant parties i.e. Psychology, SPS, Psychiatry, OT, Social Care, Nursing ) |
| Is an AMHP involved in the person’s care? Name of AMHP. |
| Evidence of need for containment/safety?  |
| Evidence of client motivation for placement and engaging in change. |
| Has this referral been discussed in an MDT/Partnership agencies meeting? Please attach evidence to support. |
| Please outline the **staying in touch plan** whilst the client is out of area and the keyworker identified to lead on this. |
| Please outline the **plan for** **transition** back into our services after the placement ends.  |
| If a specialist placement is not agreed upon, what would be the likely risks to client and staff? What support will be needed to manage the patient within the Community or local Hospital setting? What would be the impact on other services i.e. ambulance, police, A&E, GP? |
| **RAPID BREAKDOWN OF PLACEMENT**If possible to outline, what would be the contingency plan in the event that there was a rapid placement breakdown? What needs would have to be considered i.e Housing, benefits, inpatient admission, drug and alcohol, medication, social networks?  |
| Who are the key people needed to attend an extraordinary meeting to plan for the client’s transition back into local care in this instance?  |
| Date:   |
| Name: Signature:Designation: |

**CCG Funded Specialist Placements Panel Outcome Form for Mental Health**

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| **Date of Specialist Placements Panel meeting referral was discussed at:** |
| **Present: please sign and add guest names.**Jo Wolfe Dawn PetersMichael StephensonJenni JordanFran AshtonPatricia DineenGill BlackburnAlly CouchAndrea Pounder- HullJeanette Passey-ERGuests and team represented: |
| **Paperwork/ reports reviewed: Please tick if reviewed and add other documents submitted if not listed.** AuditCare planClinical Psychology DASTFormulation GRIST- or other risk assessment toolMental health assessment MAPPA or MARAC informationMulti-agency Nursing OT Psychiatry Social Care / AMHPSPS Specialist reportsRisk and relapse plan |
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| **Reasons/rationale for not recommending a specialist placement:** |
| **Suggested recovery plan deemed suitable for client’s needs from within area:** |
| **Actions necessary to ensure this occurs (state action and responsible person):** |
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| **Reasons/ rationale for recommending a specialist placement:** |
| **Suggested treatment, duration of placement and name of recommended placement deemed suitable for client’s needs:** |
| **Any identified service shortfalls that would otherwise enable the client to stay in area:** |
| **Name and designation of SP panel person leading on this case:** |
| **Date of review (SP panel meeting) if referral recommended:** |
| **Has the client been offered a copy of this form?** |
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| **Date taken to Mental Health Care Group meeting to discuss :**  |
| **Agreed: Not agreed:** |
| **Authorised by Director: (print name)**  |
| **Signed:** |
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| **Date taken to Trust Wide Patient Flow meeting to discuss and by whom:**  |
| **Outcome**  |
| **Recommended for submission to CCG**  |
| **Not Recommended for submission to CCG** |
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| **Final CCG decision:** |
| **Rationale:**  |
| **Signed by:** |
| **Printed Name: Date:** |