Moxham House
8 Culverden Park Road
Tunbridge Wells
Kent. TN4 9QX

Psychiatry Report

APPLICATION FORM

It would be appreciated if you filled in the sections below as fully as possible. We have found that the more information we have concerning clients before they come to stay with us helps greatly in providing the right sort of continuing care from the start. Thank you for your time.

Name of client:

Current Diagnosis:

Does the client now, or has he/she previously suffered from any of the following: please include in your comments dates, time scales, how the conditions are manifested, and how they have been treated.

- Perception disorders
- Auditory/Visual hallucinations
- Delusional beliefs
- Thought disorder
- Bi-polar disorder

- Depression

- Panic attacks

- Emotional disorders (including inappropriate emotions and blunting)

- Obsessive-compulsive disorder

- Hysteria

- Eating disorders

- Level of motivation

- Level of self-care

- Social withdrawal

- Loss of pleasure

Behavioural Challenges - Suicide attempts
- Parasuicide attempts/self harm
- Inappropriate behaviour
- Violence towards people
- Violence towards property
- Verbal aggression
- Anti-social behaviour
- Personality disorder
Has there been any assessment under the Mental Capacity Act 2005 or any Safeguarding-related issues?
Other medical problems - Impaired mobility

Learning difficulties
Alcohol/drug (substance misuse)
- Impaired hearing/sight/speech
- Long-term illness/infection
- Allergies

Please give any signs and symptoms that may indicate a decline in the client's mental health

Medication

Drug & Dosage	Route	Purpose	Side Effects Experienced	Date Started

How compliant is the client in taking this medication?

If the client is self-medicating, how long have they been doing so?

Past hospital treatment

Hospital	Dates	Treatment Given	Under Section of MHA?

Is the client currently/will be discharged on any section of the MHA 1983/2007 (including s117)**Yes / No**?
If **YES** which one(s)?

Prognosis and where possible, if a discharge summary (or report for housing provider) is not included, give advice for further management.

Family Structure: Please include details of relevant family psychiatric history.

Risk Assessment: Please provide details of a recent risk assessment in respect of this client

What are the assessed rehabilitation and therapeutic needs?

For applications outside KMPT area, I, on behalf of my NHS/CCG Trust, agree to provide continuing psychiatric care for this client for at least six months and will transfer him to Kent & Medway NHS & Social Care Partnership Trust (KMPT) after this period, if this application to Crossways Community is successful.

_____	_____
Signature:	*Date:*
_____	_____
Please print name:	*Position Held:*
_____	_____
Contact number:	*Contact email*