AMHP Referral Form for Breathing Space

* All referrals to be emailed to AMHP Service for recording.
* To be completed by all AMHPs considering A Mental Health Crisis Breathing Space (MHCBS).

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| AMHP Service contact details; | |  |
| Bedfordshire and Luton | 01234 315706  *Mon-Thurs: 9am–5pm*  *Fri: 9am–4:30pm* | [elft.breathingspace-bedsluton@nhs.net](mailto:elft.breathingspace-bedsluton@nhs.net) |

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| Consent to share information |  |  |  |
| MHCBS can only be progressed if a person concerns to their information being shared. | | | | |
| Does the person have capacity to consent to this referral. | Yes/no | | | |
| If yes, has the MHCBS Consent Form been attached to this referral | *Referrals can only be accepted with this form completed.* | | | |
| If no, has the Mental Capacity Assessment and Best Interests Decision form been attached to this referral. | *Referrals can only be accepted with this form completed.* | | | |

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| Referral Information |  |  | |  |
| **Date and Time Referral sent:** | **Referrer Name:** | | | | |
| **Role:** | | | | |
| **Organisation:** | | | | |
| **Contact Number:** | | | | |
| **Email:** | | | | |
| **Service User Name:** | **Date of Birth:** | | **Age:** | | |
| **Address:** | **NHS Number:** | | | | |
| **Telephone No:** | **GP Details:** | | | | |
| **Care Co-ordinator / Mental Health Team Details:** | **Does the Mental Health Team have an Approved Mental Professional (AMHP) within the team: Y/N** | | | | |
| **Name of Team AMHP:** | | | | |
| **Family Contact Details:** | **Communication Needs (Interpreter required, sign language, deaf or Blind, Flash cards etc.):** | | | | |

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| Nominated Person |  |  |  |
| **To support the MHCBS a Nominated Person must be identified, this can either be a team AMHP, care co-ordinator or mental health nurse *(Please note a nominated person will be contacted to provide regular updates regarding a person’s crisis, in the event they fail to respond the MHCBS will be ended).* Please detail the Nominated Persons details** | | | | |
| **Nominated Person’s Name;** |  | | | |
| **Nominated Person’s Role:** |  | | | |
| **Nominated Person’s Contact number:** |  | | | |
| **Nominated Person’s email address:** |  | | | |

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| Referral information |  |  |  |
| **To support the AMHP with decision making around MHCBS, the following information is required;** | | | | |
| **Does the person reside in England or Wales;** | **Yes/No** | | | |
| **Has the person been removed to a place of safety by police (S135 or S136 MHA);** |  | | | |
| **Does the person have a mental disorder of a serious nature;** |  | | | |
| **Is the person receiving crisis, emergency or acute care or treatment in hospital or the community from specialist services in relation to a mental disorder of a serious nature *(specialist mental health service includes, CMHT, crisis houses or CRHT).*** |  | | | |
| **Is the person experiencing issues with problem debt, please detail as much information as possible;** |  | | | |

Review & Decision Making

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| Details | |  |  |  |
| To be completed by AMHP / EDT Lead | **Date and Time of Review:** | **Name & Role of Reviewer:** | | | |
| **Outcome of Reviewer:** | **Name of AMHP allocated to give referral further consideration:** | | | |
| **Rationale for Review Decision:** | | | | |

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| To be completed by the AMHP Professional | Date referral and MHCBS considered. |  |
| Time referral and MHCBS considered. |  |
| Outcome of AMHPs consideration, was certification/approval provided; |  |
| If MHCBS certification/approval provided, date and time submitted; |  |
| Time taken for AMHP to complete all consideration and recording; |  |