



### Initial Triage Form

<b>NAME:</b>		<b>PREVIOUS NAME:</b>		<b>DATE OF REFERRAL:</b>	
<b>ADDRESS &amp; POSTCODE:</b>		<b>TEL NO:</b>		<b>DOB:</b>	
<b>ETHNICITY:</b>	<b>RIO NO:</b>	<b>REFUGEE:</b>	<input type="checkbox"/>	<b>VETERAN:</b>	<input type="checkbox"/>
				<b>ASYLUM SEEKER:</b>	<input type="checkbox"/>
				<b>ENGLISH NOT FIRST LANGUAGE:</b>	<input type="checkbox"/>
<b>Any medically unexplained physical symptoms?</b>				<b>Any long-term conditions?</b>	
<b>Perinatal</b>	<input type="checkbox"/>	<b>Offenders</b>	<input type="checkbox"/>	<b>Learning Disabilities</b>	<input type="checkbox"/>
<b>RELIGION:</b>		<b>NEXT OF KIN;</b>		<b>ADDRESS:</b>	
<b>RELATIONSHIP</b>		<b>EMERGENCY CONTACT NO:</b>			
<b>PREFERRED METHOD OF CONTACT:</b>				<b>VERBAL CONSENT TO SHARE INFORMATION:</b>	
<b>NHS NO.:</b>		<b>GP: SURGERY:</b>		<b>REFERRING AGENT:</b>	
<b>DATE OF TRIAGE:</b>					
<b>TIME OF TRIAGE:</b>					
<b>SCREENING ASSESSMENT:</b>					
<i>Client's perception of problem / need / duration / any significant life events</i>					
<i>Past involvement in Mental Health Services inclusive of forensic history</i>					

**Household composition**

Are there any children living in your household?

Names

Date of Birth

Relationship

Do you have carer's responsibilities?

**OTHER PROFESSIONALS INVOLVED (H/Visitor, Social Worker, Probation, Surestart etc)**

**RISK PROFILE:**

RISK OF VIOLENCE/HARM TO OTHERS:  
RISK OF SUICIDE:  
RISK OF DELIBERATE SELF HARM:  
RISK OF SEVERE SELF NEGLECT/DOMESTIC:  
RISK OF ADULT ABUSE:  
RISK TO CHILD:  
RISK OF EXPLOITATION:  
RISK RELATED TO PHYSICAL CONDITION:  
OTHER: Child Protection, Domestic Violence, MAPPA, POVA

Guide to current risk:  
0 – No apparent risk  
1 – Low apparent risk  
2 – Significant risk  
3 – Serious apparent risk  
4 – Serious and imminent risk

**FORMULATION OF RISK:**

**RISK FACTOR ISSUES / PROTECTIVE FACTORS:**

**RECOMMENDED ACTION BY PRACTITIONER:**

**PERMISSION TO LEAVE MESSAGE ON TELEPHONE:**

**TRIAGED BY:**

**NAME:**

**DATE:**

**DOES THE CLIENT REQUIRE A COPY OF THE INITIAL TRIAGE FORM? (YES/NO PLEASE SPECIFY)**