**Appendix 16 Out of Area Patient ICB Notification Form**



A picture containing text

Description automatically generated

**Out of Area Patient ICB Notification Form**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of person completing the form |  | | Job Title |  | |
| Email address |  | | Contact Number |  | |
| Patient name |  | | Date of Birth |  | |
| NHS Number |  | | Ethnicity | Choose an item. | |
| Gender | Choose an item. | | Identity | Choose an item. | |
| GP Practice | Rotherham | Doncaster | | | North Lincolnshire |
| Choose an item. |  | | |  |
| Formal diagnosis | **kdsfjd** | | | | |
| Does this person have a diagnosis of Autism or Learning Disability | | | Choose an item. | | |

**Section 1 – Assurance of responsible commissioner**

**Please complete this section prior to booking an out of area placement to confirm who the responsible commissioner is.**

|  |  |  |  |
| --- | --- | --- | --- |
| Reason for out of area Placement admission |  | | |
| Is this placement considered appropriate or inappropriate | Choose an item. | | |
| What is the patients MHA status |  | | |
| Who do you believe is the responsible commissioner | Choose an item. | **If other, please specify:** |  |
| What is your rationale for choosing the above responsible commissioner |  | | |
| Has the patient previously been detained under section 3,37,45A,47 or 48? | Choose an item. | | |

**Section 2 – Notification of Out of Area Placement**

**Please ensure all details below are completed before sending a copy of this document, plus copies of any completed Private Provider referral forms to the identified responsible commissioner.**

|  |  |  |  |
| --- | --- | --- | --- |
| Admission date |  | Ward type | **Choose an item.** |
| Name and contact details (email) for the Private Provider |  | | |
| Name and address of Hospital placed |  | | |
| Contact details for the ward manager or ward clerk |  | | |
| Daily / weekly rate of placement |  | | |
| Special Obs/1:1 agreed \* (If yes, please provide details) | Choose an item. | Comments: |  |
| Special Obs/1:1 Rate |  | | |
| Any other costs i.e. transport (If yes, please provide details) | Choose an item. | Comments: |  |
| Any further comments/details |  | | |
| Date form completed |  | | |

**\* If Special Obs/1:1 are agreed, Private Provider to be advised that Special Obs/1:1 forms will be required to be completed and submitted to the responsible commissioner, a copy of the form will be sent by email following the placement being made.**

**\* RDaSH are responsible and pay for transport to and from NHS facilities. The responsible commissioner will pay for transport between private facilities.**

**Please return this completed form to the identified responsible commissioner within 24 hours of the placement or the next working day:**

|  |  |  |
| --- | --- | --- |
| Identified Responsible Commissioner | Contact name | Contact Email |
| SY ICB – Rotherham | S117 team | [syicb-rotherham.rotherhamcomplexcasemanagement@nhs.net](mailto:syicb-rotherham.rotherhamcomplexcasemanagement@nhs.net) |
| SY ICB – Doncaster | SY ICB – Doncaster Continuing Care Team | [syicb-doncaster.doncastercontinuingcare@nhs.net](mailto:syicb-doncaster.doncastercontinuingcare@nhs.net) |
| Humber and North Yorkshire ICB – North Lincolnshire | Katie Robinson | [hnyicb-nl.mentalhealth@nhs.net](mailto:hnyicb-nl.mentalhealth@nhs.net) |