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**Risk Assessment Form for GP, Medical Professional or Mental Health Practitioner to Complete**

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| Name of Patient: |

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| Mental Health diagnosis or condition? |
| Any other medical condition? |
| Current medication? |
| Any current risk to self (including suicidal thoughts)? |
| Any current risk to others, including; violence, sexually inappropriate behaviour, financial exploitation? |
| Triggers to risk? |
| Any specific things we can do to minimise risk? |
| Does this individual have a criminal history? If yes can you please give more details |
| Current drug and alcohol status? |
| Any Previous occurrences of above? Please give dates and details. |

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| Name of GP completing this form: | Sign | Date |
| Or Name of Medical Practitioner completing this form: | Sign | Date |