***Referral Form*:**

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| ***1. Consent:***   * Has the referrer met with the child or young person? …………………………. Please check  Yes / No * Has child / young person given consent to referral? …………………………. Please circle Yes /  No * Has parent / guardian given consent to referral? …………………………. Please circle Yes /  No * Has the parent/young person consented to transfer   of referral information to a CAMHS partnership agency if  assessed as more appropriate for their needs? …………………………. Please circle  Yes / No   * Consent to store information on secure YPAS database …………………………. Please circle Yes / No |

***2. Details of the child / young person:*** Date: Click here to enter a date. Taken Click here to enter text.By:\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Name:**  **Previous Surnames:** Click here to enter text.  **Address:**  **Postcode:**  **Main Tel No:**  **Other Tel No:**  **NHS Number:** *(If not known YPAS will obtain)*  **Age:**  **Date of Birth**:  **Ethnicity:**  **How would you describe your gender?**  **How did you hear about our services?** |

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| ***Who has parental responsibility?***  **Parent / Carer’s name:**  **Parent’s Address** (*if different from above)***:** Click here to enter text.  **Parent’s contact number:**  **Legal Status:**  Care of Parent Click here to enter text.  Care of Local Authority – Liverpool/Sefton/other  Section 20 Voluntary  Full Care Order  Interim Care Order  Care Order places at home  Child Protection Plan  Other Carer – give details  Details: Click here to enter text.  Safeguarding/Access: Click here to enter text. |

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| **Who can we contact?**    **You: Yes**  **No**  **Others:** **Yes**  **No**  **How?** **Phone**  **Post**  **Email**  **Text**  Details: Click here to enter text.  **Name of Emergency contact:** Click here to enter text.  **Relationship to you:** Click here to enter text.  **Telephone No:** Click here to enter text. |

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| **School/Education provider:**  **Year group:**  **Key School Contact:**  **NEET:** Yes / No  **Is there a statement of educational needs or EHC plan?**  Y / N  **Is there an E-HAT open –** Yes / No  **Is the young person a Child in Need -** Yes / No  **Is the young person in employment -** Yes / No |

***3. Professionals involved:***

Please list all professionals with current contact details (phone and email)

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| ***4. GP Details*** *(if not referrer)* Are you registered? Yes  No  Don’t Know  Doctor’s Name:  Surgery Address:  Surgery Tel No: |

***5. Reason for Referral:***

***5a.***Please give a brief description of the child/young person’s emotional/behavioural or mental health difficulties.

***5b****.*

What help and outcomes is the young person / family / professional expecting from this referral?

***5c.***

Please list the impact the child or young persons diffculities are having on their education.

***5d.***

How long have these problems been an issue? years/months

***5e****.*

Any identified risk factors?

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| --- | --- | --- | --- |
| ***6. Presenting Issues:*** | | | |
| Anger | Depression | Grief / Loss | Relationships |
| Anxiety | Disability | Hearing Voices | School |
| Assault | Domestic Abuse | OCD | Self Esteem |
| Attempted Suicide | Substance Misuse | Parental Mental Health | Self-Injury |
| Behaviour | Eating Issues | Parental Separation | Sexual Abuse |
| Bereavement | Family | Parental Substance Use | Sexuality |
| Bullying | Gender Identity | Rape | Trauma |
| Low Mood Other (please describe): Click here to enter text. | | | |
|  | | | |

***7. Developmental Concerns:***

Please indicate whether the child / young person has any specific learning difficulties (state nature and severity). This may include reference to attention difficulties, social and communication difficulties and delays in reaching milestones.

***8. Adaptations:***

Does the child / young person require any adaptations for attending appointments? E.g. venue, time, translation.

Click here to enter text.

Practitioner/Worker: Male Female  Doesn’t matter

|  |  |  |  |
| --- | --- | --- | --- |
| ***9. Family:*** *Please detail all relevant family members* | | | |
| **Name** | **Age** | **Relationship to child** | **Currently live with child?** |
|  |  | Click here to enter text. |  |
|  |  | Click here to enter text. |  |
|  |  | Click here to enter text. |  |
|  |  | Click here to enter text. |  |
| Click here to enter text. |  | Click here to enter text. |  |

***10a.*** What services have already been received?

***10b.*** What was the outcome?

Click here to enter text.

Appointment time: Daytime Evening Doesn’t matter  
  
Appointment day: Monday Tuesday Wednesday   
 Thursday Friday  Saturday

Doesn’t matter

**Referrer Details**

Date: Name:

Role:

Organisation:

Address:

Telephone Number: Fax number: Click here to enter text.

Email Address: Click here to enter text.

**YPAS office use only:**

Service required? Letter Text Email Call

Yes to Couns? Yes No

Service required:

Individual Therapy Systemic Family Practice  Anger Awareness Group Self-Injury Group

Trans Group IAG Drop-In Parenting

GYRO  GP Champs

Additional Information: **Waiting List Number:** Click here to enter text.

Click here to enter text.