***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 detailsDetails: 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.