Referral Form:

1. Consent:

- Has the referrer met with the child or young person? ..... Please circle 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:_____ Taken By:_____

Name: _____
Previous Surnames: _____
Address: _____
_____
Postcode:_____
Main Tel No: _____
Other Tel No: _____

Age: _____
Date of Birth: _____

Ethnicity: _____

How would you describe your gender? _____

How did you hear about our services? _____

Who has parental responsibility? _____

Parent / Carer's name:
_____

Parent's Address (*if different from above*)**:**
_____
_____
Parent's contact number: _____

Legal Status:
☐ Care of Parent _____
☐ 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: _____
Safeguarding/Access:_____

Who can we contact?

You: **Yes** ☐ **No** ☐
Others: **Yes** ☐ **No** ☐
How? **Phone** ☐ **Post** ☐ **Email** ☐ **Text** ☐
Details: _____

Name of Emergency contact: _____
Relationship to you: _____
Telephone No: _____

School: _____
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 young person a Child in Need? - Yes / No

3. Professionals involved:

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

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?

_____

_____

_____

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): _____		

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.

_____

Practitioner/Worker: ☐ Male ☐ Female ☐ Doesn't matter

9. Family: *Please detail all relevant family members*

Name	Age	Relationship to child	Currently live with child?
			☐
			☐
			☐
			☐

10a. What services have already been received?

_____

_____

10b. What was the outcome?

_____

_____

_____

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: _____

Email Address: _____

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:**