

***YPAS Referral Form*:**

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| ***1. Consent:**** Has the referrer met with the child or young person? [ ]  Yes /[ ]  No
* Has child / young person given consent to referral? [ ] Yes / [ ]  No
* Has parent / guardian given consent to referral? [ ] 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? [ ]  Yes / [ ] No * Consent to store information on secure YPAS database [ ] Yes /[ ]  No
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| ***2. Details of the child / young person:*** **Name:** Click here to enter text. **Previous Surnames:** Click here to enter text.**Address:** Click here to enter text.**Postcode:** Click here to enter text.**Main Tel No:** Click here to enter text.**Other Tel No:**  Click here to enter text.**NHS Number:** *(If not known YPAS will obtain)* Click here to enter text.**Age:** Click here to enter text.**Date of Birth**: Click here to enter a date. **Ethnicity:** Click here to enter text. **How would you describe your gender?** Click here to enter text.**How did you hear about our services?**  Click here to enter text. |
| ***3. Parental Responsibility:*** ***Who has parental responsibility?*** Click here to enter text.**Parent / Carer’s name:** Click here to enter text. **Parent’s Address** (*if different from above)***:** Click here to enter text.**Parent’s contact number:** Click here to enter text.**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 below.Details: Click here to enter text. Safeguarding/Access: Click here to enter text. |
| ***4. who can we contact:*** **You:** [ ] Yes / [ ] No**Other:** [ ] 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. |
| ***5. School Details:*** **School/Education provider:** Click here to enter text.**Year group:** Click here to enter text.**Key School Contact:** Click here to enter text.**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 |
| ***6. Professionals involved*** **List all professionals with current contact details (phone and email)**Click here to enter text. |
| ***7. GP Details*** *(if not referrer)* Are you registered? Yes [ ]  No [ ]  Don’t Know[ ]  Doctor’s Name: Click here to enter text.Surgery Address: Click here to enter text.Surgery Tel No: Click here to enter text. |
| ***8.Reason for Referral:*****Give a brief description of the child/young person’s emotional/behavioural or mental health difficulties.** Click here to enter text.**What help and outcomes is the young person / family / professional expecting from this referral?**Click here to enter text.**List the impact the child or young persons diffculities are having on their education or Employment.**Click here to enter text.**How long have these problems been an issue? (years/months)** Click here to enter text.**Any identified risk factors?**Click here to enter text. |
| ***9. 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.  |
| ***11. Developmental Concerns:***Please indicate whether the child / young person/family member has any specific learning difficulties (state and severity). This may include attention difficulties, social and communication difficulties, and delays in reaching milestones.Click here to enter text. |
| ***12. 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**.** |
| ***13. Family:*** ***Please detail all relevant family members***  |
| ***Name*** | ***D.O.B*** | ***Relationship to Child*** | ***Possible support required*** | ***Contact details: phone number, address etc.*** |
| Click here to enter text. | Click here to enter a date. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
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| ***14. Referrer Details:*****Date:** Click here to enter a date.**Name:** Click here to enter text.**Role:** Click here to enter text.**Organisation:** Click here to enter text.**Address:** Click here to enter text.**Telephone Number:** Click here to enter text.**Email Address:** Click here to enter text. |
| ***15. Additional Information:*****What services have already been received?**Click here to enter text.**What was the outcome?**Click here to enter text.**Any further information to support in understanding the Young Person and their need?**Click here to enter text. |