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***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 | | | | |
| ***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. | | | | |