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| **Child/Young Person’s Details** |
| **Name:**  | **Address:**  |
| **Gender:**  |
| **Date of Birth:**  |
| **Contact No.:**  |
| **Nationality:**  |

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| **Parents Details** |
| **Name:**  | **Address:**  |
| **Gender:**  |
| **Date of Birth:**  |
| **Contact No.:**  |
| **Nationality:**  |

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| **Consultant Psychiatrist** |
| **Name: Dr.**  | **Contact No.:**  |
| **Address:**  |

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| **CAMHS Key Worker** |
| **Name(s):**  | **Job Title(s):**  |
| **Address:**  | **Phone Number:**  |

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| **ICP No.**  | **Date ICP completed** | **Next ICP review date** |
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| **Formulation *(including strengths)*** |
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| **Goals** |
|  | Goals | Child/Young Person/ Parent/Guardian |  Rate 1-10 (Now) | Rate 1-10 (Goal) |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |

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| **Actions/ Plan** |
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| **Other agencies involved:** |
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| **Additional information/comments:** |
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| ICP discussed/agreed with child/young person: | Yes/No | Date: |  |
| ICP discussed/agreed with both parent(s)/guardian(s): | Yes/No | Date: |  |
| Copy of ICP given to child/ young person and parents: | Yes/No | Date: |  |
| Database updated: | Yes/No |  |
| Projected Discharge Date: |  |
| ICP completed by: (Print Name/Title) | Signature: |
| Child/Young Person: | Signature: |
| Parent(s): | Signature: |