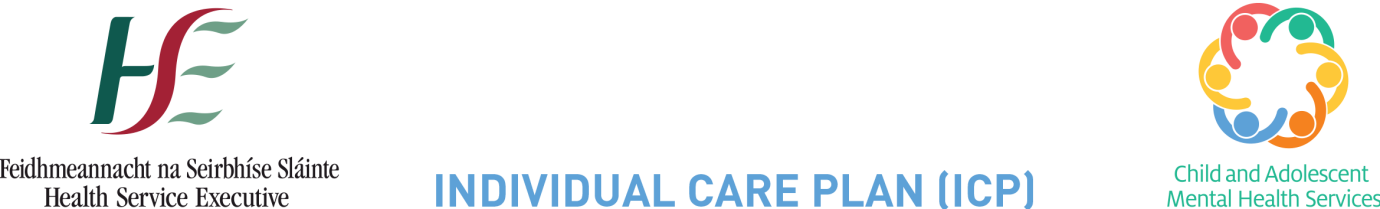
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|  |  |
| --- | --- |
| **Child/Young Person’s Details** | |
| **Name:** | **Address:** |
| **Gender:** |
| **Date of Birth:** |
| **Contact No.:** |
| **Nationality:** |

|  |  |
| --- | --- |
| **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:** |

|  |  |  |
| --- | --- | --- |
| **ICP No.** | **Date ICP completed** | **Next ICP review date** |
|  |  |  |

|  |
| --- |
| **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** |
|  |

|  |
| --- |
| **Other agencies involved:** |
|  |

|  |
| --- |
| **Additional information/comments:** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| 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: | |