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| ***Important note to referring Referrer:*** *Please complete all sections. Failure to provide requested information could result in a delay in assessment. Please attach any other clinical reports that are relevant to this referral.* |
| **Details of which CAMHS Team Referral is being sent to:**  |
| **CAMHS Consultant:**        | **Address:**       |
| **Contact No(s).:**        | **Fax No.:**        |
| **Email:**        |

|  |  |  |
| --- | --- | --- |
| **Name of child:**        | **DOB:**        | **Gender:** |
| **Parents/Carer Contact No.:**        |
| **Name of child’s GP:**        | **Date GP Informed:**        |
| **Practice Address:**        |

|  |  |  |
| --- | --- | --- |
| **Please tick** | **Yes** | **No** |
| G.P informed of Referral |  |  |
| In Writing |  |  |
| By Telephone |  |  |

 |
| **School/ Occupation:**        | **Family Composition:**        |
| **How long have you known the child/young person?**        |
| **Describe the presenting problems, symptoms, when did they start and other problems identified:**       |
| **What is the child/young person’s current mental state?**       |
| **What risk and/or resilience factors are currently present?**       |
| **Is the child/ young person currently suffering from any medical problems?** **If so describe:**        |
| **Has the child/young person been previously referred to:**

|  |  |  |
| --- | --- | --- |
| **Please tick** | **Yes** | **No** |
| Social Services |  |  |
| Another Mental Health Service |  |  |
| Psychology Service |  |  |
| This Service  |  |  |

 | **If yes to any, please provide details:**        |
| **Have you obtained consent for this referral:****Yes/No** *(it is advisable that consent is sought from both parents if practicable, however one is sufficient)*

|  |  |  |
| --- | --- | --- |
| **Please tick** | **Yes** | **No** |
| Both Parents |  |  |
| Mother only |  |  |
| Father only |  |  |
| Neither parent |  |  |
| Other *(Please specify)* |  |  |

 | **If, ‘Other’, please specify:**        |
| **Are there other agencies currently involved with the child/ young person?**

|  |  |  |
| --- | --- | --- |
| **Please tick** | **Yes** | **No** |
| Community Care Social Work |  |  |
| Paediatrician |  |  |
| Community Care Psychology |  |  |
| Speech & Language |  |  |
| Autism Services |  |  |
| Tusla - Child and Family Agency  |  |  |
| Other *(Please specify)* |  |  |

 | **If yes to any, please provide details:**        |
| **Referrer’s Name:**        | **Referrer’s Address:**        |
| **Referrer’s Clinical Discipline:**        | **Date of Referral:**        |
| **Contact No.:**        | **Fax No.:**        |
| **E-mail:** |