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| *The Parents/Carers and Young Person has agreed to have this document sent to**GP* [ ] *and/or* if relevant,  *Referring Agent/Adult Mental Health Service (AMHS)/Other Named Service* [ ]  **Further information can be provided if required, by contacting our service directly.** | |
| **To: General Practitioner** | **To: Referring Agent / AMHS / Other Agency** |
| **Name:**  **Address:** | **Name:**  **Address:** |

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| **CC. to:** |

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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. | |  |
| **Address:** | **Phone Number:** | |

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

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| **Original reason for referral** |
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| **Discharge Information** |
| Discharge Plan discussed with young person & family/carer? Yes  No  Notification of discharge/service transfer given to young person and family?Yes  No  Any other relevant information given to young person or parent/guardian: |

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| **Brief Service Summary** | |
| **Formulation:** | |
| *Description of presentation, including diagnosis, onset, frequency, duration, features, consequences, precipitating and maintain factors and stressors:* | |
| **Outcome** | |
|  | |
| **Discharged to the care of:** |  |

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| **Treating Consultant Psychiatrist**  **(Print name):** |  | **Consultant Child & Adolescent Psychiatrist** |  |
| **Signed:** |  | **Date:** |  |

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| **Key Worker  (Print name):** |  | **Discipline:** |  |
| **Signed:** |  | **Date:** |  |