****

|  |
| --- |
| *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:**       |

|  |
| --- |
| **CC. to:** |

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

|  |
| --- |
| **Consultant Psychiatrist** |
| **Name:** Dr.       |  |
| **Address:**       | **Phone Number:**       |

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

|  |
| --- |
| **Original reason for referral** |
|       |

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

|  |
| --- |
| **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:** |       |

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

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