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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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| **Concerns/Incidents** *(Please tick and provide further explanation of any relevant concerns/incidents in the spaces provided below)* |
| **Suicide and Safety** | **Yes** | **No** |
| Does the child have a history of suicide attempts? *(If so provide details below)* |  |  |
| Is the child currently experiencing suicidal ideation? |  |  |
| Is there a family history of suicide? |  |  |
| Within the child’s social network have there been instances of suicide or suicide attempts. If so when? *(Provide details below)* |  |  |
| Has the child experienced or is the child currently experiencing an event, which may be perceived as traumatic *(e.g. Bullying, Physical/Sexual Abuse, Diagnosis of a Physical/mental illness etc.)* |  |  |
| Has the child experienced a significant loss either recently or in the past? *(Family member, Relationship, Pet etc.)* |  |  |
| Has the child exhibited or is the child currently exhibiting signs of inappropriate sexual behaviour? |  |  |
| Has the child in the past or is the child currently presenting with behavioural problems? |  |  |
| Has the child a history of absconding? |  |  |
| Is the child compliant with his/her current treatment plan? |  |  |
| **Additional Comments:**        |
| **Self-Neglect (Please tick the appropriate box)** | **Yes** | **No** |
| Does the child have a history of self-neglect? *(e.g. poor hygiene, inadequate dietaryintake, etc.)* |  |  |
| Does the child have a history of an eating disorder or body image problem? |  |  |
| Does the child have low self-esteem? |  |  |
| Does the child have difficulty communicating his/her needs? |  |  |
| Are there significant financial constraints that my affect the child’s ability to self-care? |  |  |
| **Additional Comments:**        |
| **Violence and Aggression** | **Yes** | **No** |
| Does the child have a history of violence or aggression towards adults, children, peers or animals? |  |  |
| Has the child ever made specific threats of harm towards others? |  |  |
| Does the child have access to, or carry weapons? |  |  |
| Is the child experiencing a psychotic episode with thoughts of violence? |  |  |
| **Additional Comments:**        |

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| **Any other relevant information:**        |