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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:**       |
| **Contact No.:**        |

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

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| **Teams details**  |
| **CAMHS Team being referred from:**  |
| **Team being referred to:**       |

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| **Checklist** | **Tick as appropriate** |
| Parental Consent obtained to transfer/transition and to provide relevant information to team being referred to? |  Yes No  |
| Detailed Referral letter sent to Team being referred to? |  Yes No |
| Copy of ICP enclosed? |  Yes No |
| Risk assessment enclosed? |  Yes No |
| Medication Record enclosed? |  Yes No |
| Physical health record enclosed? |  Yes No |
| Summary of MDT interventions enclosed? |  Yes No |

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| Additional Information provided |

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| **Completed by**  |
| **Name(s):**  | **Signature:**       |
| **Discipline:**       | **Date:**       |