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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:** |