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| ***Important note to referring Referrer:*** *Please complete all sections. Failure to provide requested information could result in a delay in assessment. Please attach any other clinical reports that are relevant to this referral.* | |
| **Details of which CAMHS Team Referral is being sent to:** | |
| **CAMHS Consultant:** | **Address:** |
| **Contact No(s).:** | **Fax No.:** |
| **Email:** | |

|  |  |  |
| --- | --- | --- |
| **Name of child:** | **DOB:** | **Gender:** |
| **Parents/Carer Contact No.:** | | |
| **Name of child’s GP:** | **Date GP Informed:** | |
| **Practice Address:** | |  |  |  | | --- | --- | --- | | **Please tick** | **Yes** | **No** | | G.P informed of Referral |  |  | | In Writing |  |  | | By Telephone |  |  | | |
| **School/ Occupation:** | **Family Composition:** | |
| **How long have you known the child/young person?** | | |
| **Describe the presenting problems, symptoms, when did they start and other problems identified:** | | |
| **What is the child/young person’s current mental state?** | | |
| **What risk and/or resilience factors are currently present?** | | |
| **Is the child/ young person currently suffering from any medical problems?**  **If so describe:** | | |
| **Has the child/young person been previously referred to:**   |  |  |  | | --- | --- | --- | | **Please tick** | **Yes** | **No** | | Social Services |  |  | | Another Mental Health Service |  |  | | Psychology Service |  |  | | This Service |  |  | | **If yes to any, please provide details:** | |
| **Have you obtained consent for this referral:**  **Yes/No** *(it is advisable that consent is sought from both parents if practicable, however one is sufficient)*   |  |  |  | | --- | --- | --- | | **Please tick** | **Yes** | **No** | | Both Parents |  |  | | Mother only |  |  | | Father only |  |  | | Neither parent |  |  | | Other *(Please specify)* |  |  | | **If, ‘Other’, please specify:** | |
| **Are there other agencies currently involved with the child/ young person?**   |  |  |  | | --- | --- | --- | | **Please tick** | **Yes** | **No** | | Community Care Social Work |  |  | | Paediatrician |  |  | | Community Care Psychology |  |  | | Speech & Language |  |  | | Autism Services |  |  | | Tusla - Child and Family Agency |  |  | | Other *(Please specify)* |  |  | | **If yes to any, please provide details:** | |
| **Referrer’s Name:** | **Referrer’s Address:** | |
| **Referrer’s Clinical Discipline:** | **Date of Referral:** | |
| **Contact No.:** | **Fax No.:** | |
| **E-mail:** | | |