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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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| **Checklist for discharge** | |
| Closure completed on Chart |  |
| Closure completed on system |  |
| HONOSCA completed |  |
| Young person and parent/carer advised to attend GP in 2 weeks for review |  |
| Relapse and protective factors discussed with young person & parent/carer |  |
| Closing Discharge Summary Form completed |  |
| Planned Case Closure recorded at weekly MDT meeting |  |
| Signatures on Closing Discharge Summary Form and dates |  |
| Copy of Closing Discharge Form forwarded to GP |  |
| Copy of Closing Discharge Form forwarded to Referrer, if not GP |  |
| Closed files to be filed in designated storage |  |

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| **Key Worker:** |  | **Discipline:** |  |
| **Signed:** |  | **Date:** |  |