CAMHS Additional Information Consent Form

Child/Young Person's Details	
Young Person's Name:	Date of Birth:
Address:	Contact No.:

Parent(s)/Guardian(s) Details	
Mother's Name:	Address:
Contact No.:	Email:
Father's Name:	Address:
Contact No.:	Email:
Guardian's Name:	Address:
Contact No.:	Email:

Consent to Contact Professionals

I/we give permission for CAMHS clinicians to request the release and/or discuss relevant clinical information about my child to support assessment and treatment.

Please provide details and tick consent:

Professional	Name	Contact Details	Consent
GP			☐ Yes ☐ No
School			☐ Yes ☐ No
NEPS Psychologist			☐ Yes ☐ No
Other Psychologist			☐ Yes ☐ No
Paediatrician			☐ Yes ☐ No
Other Medical (e.g. Neurology)			☐ Yes ☐ No
Speech & Language Therapist			☐ Yes ☐ No
Occupational Therapist			☐ Yes ☐ No
Tusla			☐ Yes ☐ No
Other (please specify):			☐ Yes ☐ No

It is our practice to invite both parents to participate in this assessment process. Your opinion is vital to us. Where parents are separated, it is important that both parents are included in the referral to our service.

Parent 1 (Mother/Father) /Guardian Signature:	Date:
Parent 2 (Mother/Father) /Guardian Signature:	Date:
If not signed by both parent's, please tell us why:	

Please ensure you have checked the following:	
Consent forms signed by parents/guardian	☐ Yes ☐ No, if No give details:
All reports of other services enclosed	☐ Yes ☐ No