CAMHS Inpatient Transfer Form

Child/Young Person's Details	
Name:	Address:
Gender:	
Date of Birth:	
Contact No (Young Person):	
Nationality:	
MRN:	
PPSN:	Medical Card Number:

Person with Parental Responsibility
Name(s)
Address:
Relationship to client:
Contact No (Person with Parental Responsibility):

Current Admission:	
Ward/Unit	
Legal Status:	Voluntary ☐ Involuntary ☐
	Child in care Yes ☐ No ☐
	If in care, please provide details: If the young person/service user is involuntary, a Mental Health Commission (MHC) Form 10 – Transfer Notification

Diagnosis/provisional diagnosis:

Name: Date of Birth:

Current Medication:
Name(s) and dosage:
Time of last dose:
Known Allergic Reactions:

Transfer from:
Name of Approved Centre:
Phone Number:
Name of Unit:
Name of Referring medical Practitioner:
Name of Treating consultant:
Name of Key Worker:

Transfer to:
Name of Approved centre, hospital or facility:
Phone Number:
Name of unit:
Name of receiving consultant (if applicable):
Reason(s) for transfer:

Decision to Transfer:	
Date of transfer:	
Time: (24 hour clock e.g. 2.41pm should be written as 14.41)	
Decision to transfer made by	
Risk Assessment conducted:	Yes ☐ No ☐
Comments:	
Transport arranged:	Yes ☐ No ☐
Escort required/arranged: If yes give details:	Yes ☐ No ☐
Has person with parental responsibility been informed of transfer:	Yes ☐ No ☐
Has the young person been informed of the reason for transfer:	Yes ☐ No ☐
If no, please provide further information:	

Name: Date of Birth:

Has the following information been included for transfer:	
Copy of Clinical notes if (applicable)	Yes ☐ No ☐
Care and treatment plan	Yes ☐ No ☐
Drug prescribing and recording sheets	Yes ☐ No ☐
Medication supply (if applicable)	Yes ☐ No ☐
Property	Yes ☐ No ☐
Weight Chart	Yes ☐ No ☐
Copy of Individual Care Plan (ICP)	Yes ☐ No ☐
Copy of Risk Assessment (RA)	Yes ☐ No ☐
Referral Letter	Yes ☐ No ☐
Other relevant information:	Yes ☐ No ☐
Information checked for completeness:	Yes ☐ No ☐

Further comments/clinical observations:
Signed:
Print Name:
Professional Registration Number:
Job Title:
Date: