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| **PROFESSIONALS REFERRAL FORM TO REFER A YOUNG PERSON INTO CNTW'S SINGLE POINT OF ACCESS - PLEASE COMPLETE ALL THE WHITE AREAS** |
| **1.** | **CONSENT TO BE REFERRED INTO A SERVICE GIVEN BY:** |
| **Child/young person** |  | **Parent/Carer** |  | **Both** |  |  **Date of Referral** |  |  |
|  |
| **2.** | **Presenting Issues:** |
|  |
| **3.** | **Identified Risk in relation to:****the child young person themselves; others (violent behaviour – risk to staff in small room); from others;**  |  |
| **Is there any evidence of self-harming** | **YES** |  | **NO** |  |  |
| **Is there any evidence of suicidal ideation**  | **YES** |  | **NO** |  |  |
| **4.** | **Has the child/young person previously been involved with other mental health/emotional wellbeing services – if so give details:** |
|  |
| **5.** | **What outcomes are expected by the child/young person being referred into a service:** |
|  |
| **6.** | **REFERRER DETAILS:** |
| **Referrer's full name :** |  | **Job title:** |  |
| **Referrer's location address:** |  | **Email address:** |  |
| **Referrer's telephone number:** |  |
| **Has the child/young person been seen by you as a Referrer:** | **YES** |  | **NO** |  |
| **7.** | **ABOUT THE CHILD/YOUNG PERSON:** |
| **NHS No.**  |  | **Gender:** |  |
| **Full Name:** |  | **Date of birth:** |  |
| **Address:** |  |
| **Main contact number:** |  | **Email address:** |  |
| **Do we have their permission to leave a voicemail/text – please tick box** | **YES** |  | **NO** |  |
| **First language:** |  | **Do you they need an interpreter?** | **YES** |  | **NO** |  |
| **Sign language required:** | **YES** |  | **NO** |  |
| **Do they need any further support to help them attend their appointment** | **YES** |  | **NO** |  |
|  **if Yes to above what support do they need:** |  |
| **Ethnicity:** |
| **Asian** |  | **Bangladeshi** |  | **Black – African** |  | **Black Caribbean** |  | **Black – Other** |  |  |  |
| **Chinese** |  | **Indian** |  |  **Mixed – White and Asian** |  | **Mixed – White and Black African** |  |  |
| **Mixed – White and Black Caribbean** |  | **Pakistan** |  | **White British** |  | **White Irish** |  |  |
| **White – Other Background** |  |  **Other** |  |  |
|  |
| **Is the child/young person a looked after child** | **YES** |  | **NO** |  |
| **Does the child/young person have a child protection plan:** | **YES** |  | **NO** |  |
| **Registered GP Practice:** |  |
| **School/college attended:**  |  |
|  **Home educated:** | **YES** |  | **Not in education employment or training:** | **YES** |  |
| **Has the child/young person an education health and care plan:** | **YES** |  | **NO** |  | **Unknown** |  |
| **Are they undertaking paid employment/apprenticeship:** | **YES** |  | **NO** |  |
| **Permission given to contact child's school/college:** | **NA** |  | **YES** |  | **NO** |  |
| **Has the child/young person any other health problems or diagnosis - give details:** |
|  |
| **8.** | **PARENT/CARER DETAILS:** | **Relationship to child/young person:** |  |
| **Full name of main parent/carer:** |  |
| **Parent/Carer contact details:** |  |
| **Does the child/young person give permission for the parent/carer to be contacted:** | **YES** |  | **NO** |  |
| **Address (if different from above):** |  |
| **9.** | **Any Supporting information:** |  |
| **Please email this referral form to :** NGSPAadmin@cntw.nhs.uk |

Date: November 2022

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