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| **REFERRER DETAILS *\*Please see notes at the end of the form for your information\**** |
| **Date of Referral:** |  |
| **Name of Referrer:** |  |
| **Organisation Name Address & Postcode:** |  |
| **Telephone Number(s):** |  |
| **Email:** |  |
| **Referrer’s professional relationship to Child/YP.** **E.g. GP/Class Teacher/SENCO:** |  |
| **Who with Parental Responsibility supports & consents to the referral? Who gives consent?**  |  |
| **Is anyone else with Parental Responsibility not aware of the referral?** |  |
| **Does the Young Person Consent to the referral? (If over the age of 14 and has capacity to consent)**: **YES / NO** |  |
| **CHILD/YOUNG PERSON DETAILS** |

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| --- | --- | --- | --- |
| **Full Name of YP:** |  | **NHS No:** |  |
| **DOB:** |  | **Ethnic Origin:** |  |
| **Sex:****M / F** |  | **Identified Gender if different:****M / F/ NB** |  |
| **YP Mobile No:** |  |
| **Home Address & Postcode:** |  |
| **Other correspondence address if appropriate:** |  |
| **Name of School:** |  |
| **Address & Postcode:** |  |
| **PARENT/CARER DETAILS** |
| **Parent/Carers Name(s) :**  |  | **Who has Parental Responsibility?** |  |
| **Home Tel No:** |  |
| **Mobile No:** |  |
| **Email address:** |  |
| **Is the Young Person in Care? In/out of county:** |  |
| **Is the Young Person under a Child Protection Plan? YES / NO** |  |
| **Any Communication or access needs:****(interpreter/language/visual impairment/physical disability)** |  |
| **Family Composition and significant others (including those living at different address)** |
| **Name** | **Relationship** | **Date of Birth** | **Address** |
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| **GP AND OTHER AGENCIES** |
| **GP Practice Name Address & Postcode:** |  |
| **Name of Doctor:** |  |
| **OTHER AGENCIES currently involved with child / young person or family: Social Care / LAC / YOS*****Including names and contact details*** |
| **Organisation:** | **Profession if known:** | **Tel No / Email** |
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| **REFERRAL DETAILS** |
| **Reason for Referral:** **Please give as much detail as possible** |  |
| **How long has the problem presented** |  |
| **What impact has this had on the child & Family?** |  |
| **Referrers understanding of the problem:****(What changes have you noticed?)** |  |
| **Date Child last seen/assessed by referrer:** |  |
| **What else has been tried and for how long?** |  |
| **Any other known problems /relevant background information:** |  |
| **Relevant Family History:****i.e. any major trauma / life events / school / social life parental mental health?** |  |
| **ONLY FILL THIS SECTION IN IF CHILD/YP IS EXPERIENCING ANY SUICIDAL INTENTIONS/PLANS/ACTIONS** |
| **Does the referrer think child/YP is at immediate risk of significant self-harm?****(If yes is hospital admission appropriate?)**  |  |
| **Is child/YP self-harming?****If yes with what, when, and how often?** |  |
| **Last Self-Harm requiring Hospital Admission if applicable:** |  |
| **Expression of suicidal intent, plans, action?**  |  |
| **Sense of hopelessness/ guilt?** |  |
| **TYPE OF HELP BEING REQUESTED: Use space below****\*If unsure then please enter this into the comments section and the access team will advise based on the information that you have provided\*** |
|  |

**Type information into to blank spaces; these will automatically expand as you enter information.**

**Please fill in as much detail as possible**

**Ensure consent has been given & state by whom for the referral to be made**

**When complete return to either email:**

025spa@mpft.nhs.uk

**Or post to:**

**Emotional Health and Well-Being Access Team**

**Redwoods Centre**

**Wenlock Building**

**Somerby Drive**

**Bicton heath**

**Shrewsbury**

**SY3 8DS**

***Telephone the BeeU Access Team on: 0808 196 4501 Option 1***