**Sunderland and South Tyneside Children and Young People’s Service (CYPS)**



Monkwearmouth Hospital

Newcastle Road

Sunderland

SR5 1NB

**Tel:** 0191 566 5500

**Fax:** 0191 566 5534

**Email:** **NTAWNT.SOTcyps@nhs.net**

**Please only return completed forms to this email address and**

**not directly to clinical staff emails**

**Community CYPS - Referral Form**

**Referral Criteria**

We expect access to our service to be simple and easy. Our criteria for acceptance are:

 The child or young person must be within our age range 0-18 years

 They must either be presenting with some degree of psychological distress or mental health difficulty. This includes children and young people in special circumstances (see page 2) of the referral leaflet whereby advice, consultation and/or support is being sought.

 They must have been seen by the referrer who will undertake an assessment of need prior to referral. This will help us to prioritise cases where necessary

 They must have given informed consent to the referral being made.

The service operates from a basis of ‘no bounce’. If a child or young person is not suitable for our service we will contact you to explain why and at the same time provide advice, help or support to access a service more appropriate to meet their needs. There is an expectation that a first level intervention musty have been attempted prior to referral and information on the outcome of this included in the referral.

Anyone who would like to have a discussion about a case prior to referral can contact our helpline for advice, information or support.

Date of Referral:

Referrer Details:

Name:

Agency and Address:

 Postcode:

Contact No. / E-Mail:

Contact / Telephone No:

Has the Child / Young Person been seen by you as a referrer: Yes No

Referral will not be accepted if the Child / Young Person has not been seen by the referrer

**The information below is essential and must be completed**

**Young Person Details**

Name: Gender:

Preferred Name: DOB:

Address:

 Postcode:

Contact Telephone No: Mobile No:

Parent Telephone No:

Preferred Language:

Religion:

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

**NHS Number: (if known)**

**School / College / Employment:**

 Contact No

**Name and Address of GP:**

 Post Code: Contact No:

**Consent for this referral: (Please tick the boxes below)**

Has the young person given consent? Yes No

If no, please state reason:

Has the parent given consent? Yes No

If no, please state reason:

Parental Responsibility held by:

Parent / Carer Full Names:

Parent / Carer address if different from above: \_\_\_\_

**Other Agencies Currently Involved, or with Significant Past Involvements:**

Name: Organisation:

Telephone: Address:

Date of involvement if known:

Name: Organisation:

Telephone: Address:

Date of involvement if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_

\_\_\_\_\_

**Reason for Referral:**

(Please state the nature of the mental health difficulty and the impact this is having on the young person and family functioning, including symptoms, onset and duration. Please add any other relevant family history or information).

**What has been tried previously eg. services or interventions and what was the outcome?**

**Action or Advice given:**

**NB: A referral will not be accepted unless this section is completed.**

**If you feel this referral is urgent, please contact our Duty Team for**

**Discussion.**

**Background / Family History / Social Circumstances:**

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**Past History of Problems:**

**Do any of the following ally to the child / young person?**

**Please tick any that apply:**

Have been Looked After or accommodated including those

adopted from care

Have been neglected or abused or are subject to a

Child Protection Plan

Have a learning disability

Who have a physical disability

Who have chronic, enduring or life limiting illness (including mental illness)

Who have medically unexplained symptoms

Who have substance misuse issues

Who are homeless or who are from families that are homeless

Who have parents with problems, including domestic violence, mental and

/ or physical illness, dependancy or addiction

Of refugee and asylum seeking families

Who are at risk of, and, or have been involved in offending

Who are from minority ethnic or minority cultural backgrounds including travellers

Who are young carers

**What are your expected outcomes of this referral?**

**Identified Risks:**

Please inform us of any known risks, either in relation to the young person being a risk

to themselves or others; any risk to the young person from others (eg sexual exploitation, sexual abuse, physical abuse); or any risks that may potentially occur to staff whilst working with this young person or family

**Child Protection Plan**

Current Historical Not Known

**Feedback and Comments.** Thank you for completing this form.

**For Office Use Only**

**Accept** URGENT PRIORITY ROUTINE

**Signpost**

**Name of Clinician**

**If you wish to discuss this referral prior to sending it to the service please contact us on Telephone 0191 566 5500 and speak with a member of our team who will be happy to answer any queries you may have.**

**October 2019**