

**Newcastle / Gateshead Community Children and**

**Young Peoples’ Service (CYPS)**

Benton House 136 Sandyford Road Newcastle Upon Tyne

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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 must have been attempted prior to referral and information on the outcome of this is included in the referral.

Anyone wishing 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

White – Other Background Other

Pakistan

White British

White Irish

NHS Number: (if known)

**School / College / Employment:**

 Contact No:

**Name & 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:

**Reason for Referral:**

**Other agencies currently involved, or with significant past involvements:**

Name: Organisation: Telephone: Address: Date of involvement if known:

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(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:**

**Past history of problems:**

**Do any of the following apply 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

Have a physical disability

Have chronic, enduring or life limiting illness (including mental illness)

Have medically unexplained symptoms

Have substance misuse issues

Are homeless or who are from families that are homeless

Have parents with problems, including domestic violence, mental and

/ or physical illness, dependency or addiction

Are at risk of, and, or have been involved in offending

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 0191 246 6913 and speak with a member of our team who will be happy to answer any queries you may have.**