Northumberland Community Children and
Young Peoples' Service (CYPS)
Northgate Hospital
Morpeth
Northumberland
NE61 3BP
Tel: 01670 798 265
Fax: 01670 394 803
Email: NTAWNT.NoTcyps@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 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 ☐ Pakistan ☐ White British ☐ White Irish ☐
White – Other Background ☐ Other ☐

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: _____

_____

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:

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 ever 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 Telephone 01670 789 254 and speak with a member of our team who will be happy to answer any queries you may have.