



**Northumberland,
Tyne and Wear**
NHS Foundation Trust

**Northumberland Community Children and
Young Peoples' Service (CYPS)**

Northgate Hospital
Morpeth

Northumberland
NE61 3BP

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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

Referrals can be made via use of referral form, consultation which can be accessed via CYPS Single Point of Access, or through Locality Hub forums, or any other consultation forum i.e: SORTED/YOT.

Referrals are considered from any source including self-referrals if consent is in place from parent/carer/young person.

Service 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.
- 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
- Mental health / emotional distress that has not responded to previous mental health / emotional input.
- We also offer consultation to LAC, YOT and SORTED



Caring | Discovering | Growing | **Together**

Chair: Ken Jarrold CBE

Chief Executive: John Lawlor

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: _____

Consent to contact Education provider for further information: Yes / No

Our duty team will review this referral, however, if they feel the referral is more appropriate for another service, Does YP/Parent/Carer give consent to us passing this referral to them?

Yes / No

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: _____

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)

Does the Child / Young Person have any of the Special Circumstances listed below? Please tick all that apply:

Who are or have been looked after or accommodated including those adopted from care

Who have been neglected or abused or are subject to a Child Protection Plan

Who have a learning disability

Who have a learning difficulty

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, dependency 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 **No**

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 798 265 and speak with a member of our team who will be happy to answer any queries you may have.