|  |
| --- |
| **YOUNG PERSONS/PARENT/CARER REFERRAL FORM - PLEASE COMPLETE ALL THE WHITE BOXES** |
| **1.** | **Do you/the young person agree to information being shared with the relevant professional people – please tick box** | **YES** |  | **NO** |  |
| **Are you a young person needing support**  | **YES** |  | **NO** |  | **A Parent Carer completing form for a young person:** | **YES** |  | **NO** |  |  |
| **2.** | **Briefly describe what you/the young person needs support with right now?** |
|  |
| **Have you/the young person thought about or have you hurt yourself?** | **YES** |  | **NO** |  |  |
| **Have you/the young person thought about or attempted to end your /their life?** | **YES** |  | **NO** |  |  |
| **If Yes to the above please tell us about this?** |  |
| **3.** | **How would you/the young person like to feel after having your/their support?** |
|  |
| **4.** | **Have you/ the young person previously used any services for support, if so, who were they with and what happened?** |
|  |
| **5.** | **We need to have some further information about you/the young person to enable you/them to be seen:** |
| **NHS No. if known:**  |  | **Gender:** |  |
| **Full Name:** |  | **Preferred Name:** |  | **Date of birth:** |  |
| **Address:** |  |
| **Main contact number:** |  | **Email address:** |  |
| **Do we have your/their permission to leave a Voicemail/Text:**  | **YES** |  | **NO** |  |  |
| **What is the best way for us to contact you/them? Letter** |  | **Mobile** |  | **Email** |  | **Text** |  |
| **Do you/they need an interpreter?** | **YES** |  | **NO** |  | **Sign language required:** | **YES** |  | **NO** |  |
| **Do you/they need any further support to help you/them attend the appointment:** | **YES** |  | **NO** |  |
| **if Yes to above what support do you/they need:** |  |
| **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** |  |  |
|  |
| **Do you/the child have a current child protection plan?** | **YES** |  | **NO** |  |  |
| **Do you/the young person have a learning disability?** | **YES** |  | **NO** |  |  |
| **Are you/they wanting to make a referral for Autism / ADHD, (if so some additional forms will be sent to you when we have your completed referral):**  | **YES** |  | **NO** |  |  |
| **6.** | **Name of your parent/carer:** |  |
| **Contact details of the parent/carer:** |  |
| **Contact details of person who has parental responsibility (if different from above):**  |  |
| **Do we have permission to contact your parent/carer in an emergency?** | **YES** |  | **NO** |  |
| **7.** | **Which GP Practice are you/the young person with?** |  |
| **8.** | **Do you/the young person go to school/ college, if so which one?** |  |
| **alternatively please tick box if you/the young person are/is home educated:** | **YES** |  |  |
| **Not in education employment or training:** | **YES** |  |  |
| **Do we have your/their permission to contact your school/college** | **YES** |  | **NO** |  |
| **9** | **Do you/the young person have a Education Health Care Plan?** | **YES** |  | **NO** |  |
| **10** | **Do you/they have any other health problems, you/they would like to tell us about?** |
|  |
| **Please now either email this referral form to : NGSPAadmin@cntw.nhs.uk****Or post to: Newcastle/Gateshead Single Point of Access, For Children and Young People’s Service, Bensham Hospital, Fontwell Drive, Gateshead NE8 4YL** |

Date: November 2022

Review date due: November 2023