|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Forename of child** | **Surname of child** | |  | **Referrer Name** | | |
|  |  | |  |  | | |
| **Parent’s names** | | |  | **Designation** | | |
|  | | |  |  | | |
| **Address** | | |  | **Address** | | |
|  | | |  |  | | |
|  |
|  |
| **Postcode** | | |  |
|  | | |  |
| **School/Nursery** | | |  |
|  | | |  |
| **How long have the family lived in the UK?** | | |  |
|  | | |  | **Telephone Number** | | |
| **Contact Numbers** | **Gender** | |  |  | | |
|  | Male  Female | |  | **Fax Number** | | |
| **NHS Number** | **Date of Birth** | |  |  | | |
|  |  | |  |  | | |
| **Languages Spoken** | | **Languages Read** | | | **Is interpreter needed** | | |
|  | |  | | | Yes | No | |

**Referral information**

|  |  |  |
| --- | --- | --- |
| **Which services do you consider are needed** | | |
|  | | |
| **State if mental health needs requiring assessment by CAMHS** | | |
|  | | |
| **Principle reason for referral** | | |
|  | | |
| **Nature of concern** | | |
|  | | |
| **Any additional information that you feel is relevant?** | | |
| *(Please attach relevant documentation & reports)* | | |
| **Other professional’s / services currently involved with the family?** | | |
| *(Please provide details of relevant previous input as well if available)* | | |
| **Any Safeguarding concerns?** | | |
| Yes | No | Not known |
| *(If yes please specify with details of Social Worker if Known)* | | |
| **Any Special Education Needs** | | |
| Yes | No | Not known |
| *(If yes please specify*) | | |
| **Please record if the patient has given consent to access information recorded via the SystmOne Electronic Record System.** | | |
| *(please note referrals cannot be processed without consent obtained)*  Consent given  Dissent given  Consent obtained on patient’s behalf | | |
|  | | |
| **Views of child/parent or carer: *(optional)*** | | |
|  | | |
|  | | |
| **Signature** | | **Date** |
|  | |  |

**Once completed please return form to us by:**

|  |  |  |
| --- | --- | --- |
| **Email:** | [fypc.referrals@nhs.net](mailto:fypc.referrals@nhs.net) |  |
| **Post:** | Leicestershire Partnership Trust, Families, Young People, Children, Learning Disabilities, and Autism Services (FYPCLDA)  Room 500 Rutland Building, County Hall  Leicester Road, Glenfield LE3 8RA | |

*Where possible please complete the form electronically, if completing by hand please use additional sheets if needed. For more information view www.leicspart.nhs.uk/fypcreferrals.*