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| --- | --- | --- | --- | --- |
| **REFERRER DETAILS *\*Please see notes at the end of the form for your information\**** | | | | |
| **Date of Referral:** |  | | | |
| **Name of Referrer:** |  | | | |
| **Organisation Name Address & Postcode:** | |  | | |
| **Telephone Number(s):** | |  | | |
| **Email:** | |  | | |
| **Referrer’s professional relationship to Child/YP.**  **E.g. GP/Class Teacher/SENCO:** | | |  | |
| **Who with Parental Responsibility supports & consents to the referral? Who gives consent?** | | | |  |
| **Is anyone else with Parental Responsibility not aware of the referral?** | | | |  |
| **Does the Young Person Consent to the referral? (If over the age of 14 and has capacity to consent)**: **YES / NO** | | | |  |
| **CHILD/YOUNG PERSON DETAILS** | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Full Name of YP:** |  | | | | | | | | | | | **NHS No:** | | |  |
| **DOB:** |  | | | | | | | | | | | **Ethnic Origin:** | | |  |
| **Sex:**  **M / F** |  | | | | | | | **Identified Gender if different:**  **M / F/ NB** | | | | | | |  |
| **YP Mobile No:** |  | | | | | | | | | | | | | | |
| **Home Address & Postcode:** |  | | | | | | | | | | | | | | |
| **Other correspondence address if appropriate:** |  | | | | | | | | | | | | | | |
| **Name of School:** |  | | | | | | | | | | | | | | |
| **Address & Postcode:** |  | | | | | | | | | | | | | | |
| **PARENT/CARER DETAILS** | | | | | | | | | | | | | | | |
| **Parent/Carers Name(s) :** | |  | | | | | | | | | **Who has Parental Responsibility?** | | | |  |
| **Home Tel No:** | | |  | | | | | | | | | | | | |
| **Mobile No:** | | |  | | | | | | | | | | | | |
| **Email address:** | | |  | | | | | | | | | | | | |
| **Is the Young Person in Care? In/out of county:** | | |  | | | | | | | | | | | | |
| **Is the Young Person under a Child Protection Plan? YES / NO** | | | | | | | | | |  | | | | | |
| **Any Communication or access needs:**  **(interpreter/language/visual impairment/physical disability)** | | | | | | | | | |  | | | | | |
| **Family Composition and significant others (including those living at different address)** | | | | | | | | | | | | | | | |
| **Name** | | | | **Relationship** | | | | | **Date of Birth** | | | | **Address** | | |
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| **GP AND OTHER AGENCIES** | | | | | | | | | | | | | | | |
| **GP Practice Name Address & Postcode:** | | | |  | | | | | | | | | | | |
| **Name of Doctor:** | | | | |  | | | | | | | | | | |
| **OTHER AGENCIES currently involved with child / young person or family: Social Care / LAC / YOS**  ***Including names and contact details*** | | | | | | | | | | | | | | | |
| **Organisation:** | | | | | | **Profession if known:** | | | | | | | | **Tel No / Email** | |
|  | | | | | |  | | | | | | | |  | |
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| **REFERRAL DETAILS** | | | | | | | | | | | | | | | |
| **Reason for Referral:**  **Please give as much detail as possible** | | | | | | |  | | | | | | | | |
| **How long has the problem presented** | | | | | | |  | | | | | | | | |
| **What impact has this had on the child & Family?** | | | | | | |  | | | | | | | | |
| **Referrers understanding of the problem:**  **(What changes have you noticed?)** | | | | | | |  | | | | | | | | |
| **Date Child last seen/assessed by referrer:** | | | | | | |  | | | | | | | | |
| **What else has been tried and for how long?** | | | | | | |  | | | | | | | | |
| **Any other known problems /relevant background information:** | | | | | | |  | | | | | | | | |
| **Relevant Family History:**  **i.e. any major trauma / life events / school / social life parental mental health?** | | | | | | |  | | | | | | | | |
| **ONLY FILL THIS SECTION IN IF CHILD/YP IS EXPERIENCING ANY SUICIDAL INTENTIONS/PLANS/ACTIONS** | | | | | | | | | | | | | | | |
| **Does the referrer think child/YP is at immediate risk of significant self-harm?**  **(If yes is hospital admission appropriate?)** | | | | | | |  | | | | | | | | |
| **Is child/YP self-harming?**  **If yes with what, when, and how often?** | | | | | | |  | | | | | | | | |
| **Last Self-Harm requiring Hospital Admission if applicable:** | | | | | | |  | | | | | | | | |
| **Expression of suicidal intent, plans, action?** | | | | | | |  | | | | | | | | |
| **Sense of hopelessness/ guilt?** | | | | | | |  | | | | | | | | |
| **TYPE OF HELP BEING REQUESTED: Use space below**  **\*If unsure then please enter this into the comments section and the access team will advise based on the information that you have provided\*** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |

**Type information into to blank spaces; these will automatically expand as you enter information.**

**Please fill in as much detail as possible**

**Ensure consent has been given & state by whom for the referral to be made**

**When complete return to either email:**

[025spa@mpft.nhs.uk](mailto:025spa@mpft.nhs.uk)

**Or post to:**

**Emotional Health and Well-Being Access Team**

**Redwoods Centre**

**Wenlock Building**

**Somerby Drive**

**Bicton heath**

**Shrewsbury**

**SY3 8DS**

***Telephone the BeeU Access Team on: 0808 196 4501 Option 1***