

**North Tyneside CAMHS  
Referral form**

Date:  
Time of Call

**Details of person making the Enquiry/Referral**

Name: \_\_\_\_\_ Tel: \_\_\_\_\_  
Designation: \_\_\_\_\_ Address: \_\_\_\_\_

**Young Person**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address \_\_\_\_\_  
Tel: \_\_\_\_\_ School/College: \_\_\_\_\_  
Name of parent/carer with parental responsibility; \_\_\_\_\_  
Young Person's GP: \_\_\_\_\_

**Consent**

Is the young person aware of this CAMHS referral/enquiry? YES/ NO  
Is the parent/carer aware of the CAMHS enquiry/referral? YES/NO  
Does the caller have consent from the family/ young person to discuss this information? YES/ NO  
Has the caller been made aware that the family may later be informed of this call? YES/ NO

**Reason for Enquiry/ Referral/ Presenting Issues**

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**Risks**

Please outline any known risk issues

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Please tick and name other professionals currently involved with the child/ young person/ family

<input type="checkbox"/> Paediatrician  <input type="checkbox"/> Social Worker  <input type="checkbox"/> Occupational Therapist  <input type="checkbox"/> Health Visitor  <input type="checkbox"/> Other	<input type="checkbox"/> Educational Psychologist  <input type="checkbox"/> School Nurse  <input type="checkbox"/> Speech and Language Therapist  <input type="checkbox"/> Dietician
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Does the child/ young person have an EHA? YES/NO Does the child have an EHCP? YES/NO Will the parent/ carer be able to understand the correspondence we send?
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Is the child/ young person:

<input type="checkbox"/> Subject to child protection plan <input type="checkbox"/> Subject to a child in need plan <input type="checkbox"/> A looked after child <input type="checkbox"/> Adopted
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**Agreed Plan**

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Form Completed by (capitals)		Other CAMHS staff consulted (if applicable)	
Name		Name	
Designation		Designation	
Signature			