Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Northumberland Community Children and Young Peoples' Service (CYPS)
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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

We expect access to our service to be simple and easy. Our 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. This includes children and young people in special circumstances (**) whereby advice, consultation and /or support is being sought
- 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

The service operates from a basis of "no bounce". If a child or young person is not suitable for our service we will contact you to explain why and at the same time provide advice, help or support to access a service more appropriate to meet their needs. There is an expectation that a first level intervention must have been attempted prior to referral and information on the outcome of this is included in the referral.

Anyone wishing to have a discussion about a case prior to referral can contact our helpline for advice, information or support

*** Special circumstances are:*

- *Those with a learning disability whose behaviour is challenging*
- *Who have ever been Looked After or accommodated including those adopted from care*
- *Who have been neglected or abused*
- *Who have a learning or physical disability*
- *Who have a chronic or enduring illness*
- *Who are homeless or who are from families who are homeless*
- *Who have parents with problems including domestic violence, illness, dependency or addiction*
- *Who are at risk of, or are involved in offending*
- *Who are from a minority ethnic or minority cultural background including travelers.*

Children in these circumstances are more vulnerable to psychological distress but do not necessarily present with mental health difficulties. We are happy to discuss children and young people with you to determine whether they need our service or if not we will suggest what may be helpful.

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: _____

_____

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: _____

Date of involvement if known: _____

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)

What has been tried previously eg. services or interventions and what was the outcome?

Action or Advice given:

NB: A referral will not be accepted unless this section is completed.

If you feel this referral is urgent, please contact our Duty Team for discussion

Background / Family History / Social Circumstances:

Past History of Problems:

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, dependancy 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 ☐

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 789 254 and speak with a member of our team who will be happy to answer any queries you may have.