LLR CYP Mental & Emotional Health Triage & Navigation Service Referral Form

(Referrals to this service using this form are accepted from the following agencies ONLY: Police, Local Authority Children's Services). This form should be emailed by secure email accounts only to dhul.dhu-cypservices@nhs.net. Do not refer CYP requiring crisis support to this service, which is not an urgent or emergency service.

PLEASE COMPLETE ALL BOXES TO ENSURE THE REFERRAL IS PROCESSED
(Incomplete referrals could cause delay in processing this referral)

Referrer details:		
Date of Referral:	**Name:**	**Job title:**
Organisational Type:		**Telephone numbers:**
Organisation Name:		**Email address:**
Address:		
Please describe what services you have already provided to the child family:		

DRAFT

Child/Young Person Personal Details

Name:	**D.O.B:**	**Ethnicity:**	**Preferred First Language:**	**Is an interpreter required?**	**Gender**	**NHS number:**

Address: **Postcode:** **How long have they lived at this address?**	**Telephone:** **Mobile:** **Preferred contact:**

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FINAL Version 010520

Name of school/college/nursery	**Details of any educational healthcare plan:**

Parental details			
Name of Parent/Carer:	**Contact number(s):**	**Ethnicity:**	**Gender:**
Name of Parent/Carer:	**Contact number(s):**	**Ethnicity:**	**Gender:**

Who has parental responsibility?	**Who does the child live with?**	
Address: **(for both parents if different from young person):**	**Mother**	**Father**
Any additional needs of parent (e.g. disability/literacy/interpreter etc)		
Any additional needs of child (e.g. disability/literacy/interpreter etc)		

GP Details		
Name:	**Address:**	**Telephone:**

Status & Legal Status

Status :	Looked After Child Early Help: CIN: Care Order: Child Protection Plan:	☐ ☐ ☐ ☐
If the referral is for a Looked After Child, which area is the child from?	Leicester Leicestershire Rutland	☐ ☐ ☐
Allocated Social Worker: (please given contact details if known for ,Child Protection and/or Child In Need social worker)		
Legal status	Refugee	Yes ☐ No ☐
	Stateless Person	Yes ☐ No ☐
	Asylum Seeker	Yes ☐ No ☐

Please Complete for ALL referrals

CONSENT OF CLIENT

Is the CYP referring themself?	**Yes** ☐ **No** ☐

The information from this form will be discussed within a multi-agency professional team to assess the appropriate course of action. We will contact you in writing to advise you of the outcome. You may be contacted for more information if required. This information will be recorded on SystmOne.

I confirm that the CYP/parent or carer has consented to the referral to CYP MH Triage and Navigation Service and to the information contained in this referral form being passed to appropriate mental health service agencies for the purposes of referral. The CYP/parent or carer consents to a referral being made.

I confirm that the CYP/parents or carer has given CYP Triage and Navigation services and, if appropriate following referral, LPT CAHMS Services to access their SystmOne patient record.

Name of referrer:	
Signature of referrer:	
Date:	

Please Complete for ALL referrals

Details of the Presenting Problem

Please give details about behaviours observed/ mood/ emotions/communication/appetite/sleep:	
How long has this difficulty been present?	**Is this difficulty present in all areas?** E.g. at home, at school, socially?
Social History (Please include details of any relevant family circumstances, life events, bereavements, parental mental health / Learning Disability / Ill Health / Substance Misuse / Domestic Abuse)	

Current Diagnosis : (if known)	**Current medication: (if known)**	**Physical Health Problems**

Risk Identifiers Please tick if any of the below apply:	
☐ Undergoing an EHC assessment	☐ Self - harming
☐ Risk of social care placement breakdown	☐ Suicidal Ideation
☐ Unable to offer placement or risk of placement breakdown due to severity of needs	☐ Risk of harming others
☐ Risk of adoption breakdown or breakdown of adoption process	☐ Significant decline in a deteriorating health condition
☐ Risk of school exclusion	☐ Substance Misuse
☐ History of Abuse/Trauma	☐Concerns regarding change in presentation or behaviours which suggest a significant regression in skills

Please Complete for ALL referrals

What is working well? (Include the child and family's views) (include here what are the strengths and protective factors for the child; what is family doing to manage the need risk and dangers identified)
Child/Young Person's Views:
Family Views:

Please Complete for ALL referrals

AGENCIES WHICH HAVE SUPPORTED THE FAMILY			
Agency	**Past Involvement** (with approximate dates)	**Current Involvement**	**Contact Person and Telephone Number**
Social Care: Child Protection Child In Need			
Paediatrician			
Education(School nurse)			
Family Support			
Health Visitor			
Youth Offending Service			
Other			

ONLY For referrals where there is a suspected Eating Disorder

Please provide the additional information below:

Eating Disorder

Weight history (weight change / duration of weight change, current weight and height)	**Weight change:** **Duration of weight change:** **Current weight and height:**
Compensatory behaviours and duration use of laxatives – yes / no / frequency	**Yes** ☐ **No** ☐ **Frequency**
Self-induced vomiting – frequency	**Frequency**
Exercise – frequency / intensity	**Frequency:** **Intensity:**
Amenorrhoea	**Yes** ☐ **No** ☐
Distorted Body Image	**Yes** ☐ **No** ☐
Any other information – including results from blood tests/ investigations. Previous inpatient admissions. ECG as required	**Blood Test:** **Investigations:** **Previous Inpatient Admission(S):**
Current dietary intake	
Physical reports – BP/pulse	**BP:** **Pulse:** **BP (standing):** **Pulse (standing):**

ONLY for referrals where there is a suspected Neurodevelopmental disorder

Please provide the additional information below

Diagnosis (if known)	**Current Medication (If known)**		
Please tick the developmental areas of concern in the table below			
Developmental Areas	**No Concerns**	**Some Concern**	**Significant Concern**
Motor development			
Speech and language			
Social interaction & play (across different situations and settings)			
Self-help skills (dressing, use of cutlery, toilet training)			
Behaviour and emotional wellbeing			
Attention, concentration & listening			
Learning			
Please elaborate on concerns raised above Current situation, please describe what is happening and when, frequency, duration – giving examples of incidents or events which are having an impact on physical health, education (school), self-esteem, emotional well-being, relationships.			

ONLY for referrals where there is a suspected Neurodevelopmental disorder

Please provide the additional information below

Early developmental history
Any concerns at school or nursery Yes ☐ No ☐ If yes, please give details below
What age were concerns first noted:
Other influences impacting on the current difficulties. Please describe or enclose relevant correspondence

Note: Any additional information please attach a separate letter