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| **REFERRAL FORM FOR AN ASSESSMENT**  **FOR CHILDREN & YOUNG PEOPLE WITH SUSPECTED**  **NEURODEVELOPMENTAL / NEURODISABILITY CONDITIONS**  **CAMHS** |

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| 1. **CHILD’S / YOUNG PERSON’S DETAILS** | | | | | | | | | | |
| **First name(s):** | | |  | | | **Surname:** | |  | | |
| **Name that the child wishes to be known by:** | | | | | | |  | | | |
| **Date of birth:** | | |  | | | **Age:** |  | | | |
| **Gender:** | | Male  Female | | **Is the gender of the child the same as it was at birth?** | | | | | | Yes  No |
| **First language:** | | |  | | | **Interpreter:** | | | | Yes  No |
| **NHS Number:** | | |  | | | **GP name/address:** | | |  | |
| **Home address:** | | |  | | | | | | | |
| **Home number:** | | |  | | | **Mobile number:** | | | |  |
| **Email:** |  | | | | **Preferred method of contact:** | | | | | Mobile  Email  Post |
| **School:** | | | | | **Key person:** | | | | | |

| 1. **OTHER AGENCY INVOLVEMENT**   Please list all agencies already involved /or that have been referred to | | |
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| **Agency involved/referral** | **Name of professional** | **Contact details** |
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1. **ANY PREVIOUS NEURODEVELOPMENT ASSESSMENT**

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| **Date** | **Outcome and professional involved** |
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| **Specific difficulty** | **Parent Opinion** | **CAMHS opinion** |
| **ADHD**  Yes  No |  |  |
| **ASD**  Yes  No |  |  |
| **Presenting Mental Health Conditions (including those formally diagnosed – please also comment on risk)** |  |  |
| CAMHS involvement to date |  |  |

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|  | **Parents Opinion** | **CAMHS opinion** |
| Features of neurodevelopmental condition observed: |  |  |

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| 1. **CONSENT**   Signed consent must be obtained from the child/young person or from the person with parental responsibility for the referral to be accepted. |
| 1. **CHILD / YOUNG PERSON’S CONSENT**   **Gillick competent**  Children under the age of **16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment**. This is known as being Gillick competent. Otherwise, someone with parental responsibility can consent for them.  **Further information can be found here:** [**https://www.nhs.uk/conditions/consent-to-treatment/children/**](https://www.nhs.uk/conditions/consent-to-treatment/children/)**)** |
| **Has the child / young person consented to the referral?**  Yes  No |
| **If No please detail why:** |
| 1. **PERSON WITH PARENTAL RESPONSIBILITY** |
| **Has the person with parental responsibility consented to the referral?**  Yes  No |
| **If No has the child/young person given consent:**  Yes  No |

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| **REFERRER** | | | |
| **Full name:** |  | **Job title:** |  |
| **Date:** |  | **Base:** |  |