**Northumberland Community Children and**

**Young People’s Service (CYPS)**

Craster

St Georges Park

Morpeth

Northumberland

NE61 2NU

Tel: 01670 502700

[**mailto:NorthumberlandCYPS@cntw.nhs.uk**](mailto:NorthumberlandCYPS@cntw.nhs.uk)

Please only return completed forms to this email address and not directly to clinical staff emails

**Northumberland Community CYPS - Referral Form**

**Making a referral**

You can submit a referral to us in the following ways:

* By completing this form and sending it to us by post or email.
* By booking a consulting slot with our Single Point of Access team by calling 01670 502700
* Via consultation forums ie. Early Intervention Hub, Youth Offending Team (YOT), SORTED or completing a MARF.
* We welcome referrals from any source, including self-referrals in line with our referral criteria

**Referral Criteria**

To ensure your referral meets CYPS Referral criteria (**OR** is appropriate for CYPS) please use the checklist below (before sending your referral to us)

1. Are they registered with a Northumberland GP
2. Is the child/young person aged between 4 – 18 years
3. Has the child/young person (or the person with parental responsibility) given informed consent for the referral to be made
4. Have you seen the child and undertaken an assessment of need prior to completing the referral. This will help us to prioritise cases. (for professionals only) **or** (this is not necessary for self-referrals)
5. Is the child/young person presenting with (significant degree of) psychological distress or a mental health difficulty that has not responded to previous/first line/primary emotional/mental health interventions **You must enclose detailed information about what interventions have been undertaken and the outcomes**
6. Have you identified any significant risk (please enclose plan/advice given)
7. Has all the essential referral information - highlighted in red - been completed

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| Date of referral:  Referrer details:  Name:  Agency and address:  Postcode:  Contact number:  Email: |

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| 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 |

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| **The information below is essential and must be completed** | |
| **Young Person Details**  Name:  Preferred name: | Gender:  DOB: |
| Address:  Postcode:  Contact number:  Parent telephone number:  Preferred language:  Religion: | Mobile number: |
| 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)** | |

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| **School / College / Employment:**  Contact number: |

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| **Name and address of GP:**  Postcode:  Contact number: |

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| **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:  **Consent to contact Education provider for further information:** Yes  No  Our duty team will review this referral, however, if they feel the referral is more appropriate for another service: Does the young person/parent/carer give consent to us passing this referral to them Yes  No  **Parental responsibility held by:**  Parent / Carer full names:  Parent / Carer address (if different from above): |

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| **Other agencies currently involved, or with significant past involvements:** | | |
| Name:  Telephone: | Organisation:  Address: | |
| Date of involvement if known: | | |
| Name:  Telephone: | | Organisation:  Address: |

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| **Reason for referral:**  (Please state the nature of 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): |

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| **What has been tried previously e.g. 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:** |

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| **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, dependency 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 travelers:  Who are young carers: |

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| **What are your expected outcomes of this referral:** |

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| **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 (e.g. sexual exploitation, sexual abuse, physical abuse): or any risks that may potentially occur to staff whilst working with this young person or family: |

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| **Child Protection Plan:**  Current  Historical  Not Known |

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| **Feedback and comments:** Thank you for completing this form |

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| **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.

Telephone: 01670 502 700 and speak with a member of our team who will be happy to answer any queries you may have.

Please send completed referral to:[**NorthumberlandCYPS@cntw.nhs.uk**](mailto:NorthumberlandCYPS@cntw.nhs.uk)

**Date: 22.5.24**

**Review due: 22.5.25**