

To make a referral send this form to:

Medway Young Persons' Wellbeing Service

Address: New Horizons Academy, Park Crescent, Chatham, Kent ME4 6NR

Telephone: 0300 300 1981

Email: nem-tr.medwayypws.referrals@nhs.net



Single Point of Access Referral for Medway Young Persons' Wellbeing Service

Section 1		Name and Contact Details of Person Making Referral:	
Name:		Address:	
Job Title or Relationship to child:			
Agency (if professional making the referral):			
Telephone:	Contact Number:	Email:	
Section 2		Child / Young Person's Details	
Child's Name:	<div style="display: flex; justify-content: space-between;"> (Surname) (First Name) </div>	M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth:
Address:		NHS Number:	Social Services identification number (if known):
Postcode:		Name of School / Nursery / College: Address: Strood Academy Carnation Road Strood Rochester Kent ME2 2SX Telephone: 01643-717121 Contact Name: Mrs Gail Cox	
Home Telephone:	Parents Mobile:	First Language:	
Email Address:	Child's Mobile:	Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No Specify Which Language:	
Religion:	Nationality:	Ethnicity:	
Young Person's Preferred Method of Contact: Letter: <input type="checkbox"/> Phone: <input type="checkbox"/> Text: <input type="checkbox"/> Email: <input type="checkbox"/>			

GP Name:	GP Telephone Number:
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GP Surgery Address:	Subject to Child Protection Plan : Y <input type="checkbox"/> N <input type="checkbox"/>
	Are they a Child In Need: Y <input type="checkbox"/> N <input type="checkbox"/>
	Provide brief details of any current/previous safeguarding concerns:
	Is this a Looked After Child: Y <input type="checkbox"/> N <input type="checkbox"/> Name of Local Authority who is Responsible :

Section 3 Next of Kin and Parental Responsibility Details:

Name of Person(s) with Parental Responsibility?	Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No Specify Which Language:
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Parent / Carer's Name (if different from above):	Relationship to Young Person:
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Address:	Telephone:
	Mobile:

Email Address:

Section 4 Name of other Professionals / Agencies involved, if known:

<input type="checkbox"/> Social Care <input type="checkbox"/> Currently <input type="checkbox"/> Previously	<input type="checkbox"/> Nursery/Preschool	<input type="checkbox"/> Educational Psychologist
<input type="checkbox"/> Medway Early Help Team	<input type="checkbox"/> Educational Team (e.g. learning/behavioural support, etc.)	<input type="checkbox"/> Educational Welfare Officer
<input type="checkbox"/> Health Visitor	<input type="checkbox"/> School Nurse	<input type="checkbox"/> SENCo
<input type="checkbox"/> Previously Known to CAMHS (e.g. PMHW; Counsellor)	<input type="checkbox"/> Youth Offending Service	<input type="checkbox"/> Children With Disabilities Team (Social Care)
<input type="checkbox"/> 3 rd Sector Organisation(s)	<input type="checkbox"/> Child Development Team (Health)	<input type="checkbox"/> Hospital/Community Doctor
<input type="checkbox"/> Other (specify):		

Please provide any relevant information regarding involvement of other professionals/agencies

Section 5

Reason for referral:

Please state nature of difficulties, onset, frequency, duration, interventions tried, any relevant medical history.

Section 6

Impact on Child/ young person at school and social development:

Please describe how this impacts on the child's behaviour, social development, school/nursery/college performance/attainment, relationships, activities, wellbeing, and physical health/routines.

Section 7

Social/family background:

Please provide details of family composition, ages, occupations/employment and parental mental and physical health concerns. Sibling group, Relevant or significant life events; e.g. Divorce/separation, bereavement, domestic violence, drug/alcohol misuse.

Section 8

Medication:

Please give details of any known medications the Child/Young Person is currently taking.

Section 9

Outcomes:

Child/Young Person:

Please give details of what the child/Young Person would like to happen as a result of this referral.

Parent/Carer:
Please give details of what the parent/carer would like to happen as a result of this referral.

Referrer:
In making this referral, what outcomes are you anticipating for the Child/Young Person/Family?

Section 10 Summary of risks:

Child/ Young Person	Current (last 2 weeks)	Recent Past (last 6 months)	Historical Past (over 6 months)
Self-Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harm to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts/ intentions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical/sexual/ emotional abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant medical needs/ Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Parent/ Environment

Parental mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parenting difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Each Risk Identified, Please Provide Details:

aggressive behaviour to students and teachers, Mum is finding it increasing difficult to support Harry with his erratic behaviour and strange outbursts in school and at home.

Section 11 Information Sharing And Consent:
Please note this section is important and should be completed

Referrals cannot be made without the agreement of the parent/carer and/or young person (subject to Gillick competence). Confidentiality is respected in accordance with the Data Protection Act. We also have a duty to refer any child who may be in need of protection to Social Services. I agree to information being shared and discussed between professionals and other agencies to help me/my child and family. I understand I will be consulted following these discussions regarding any future planning and actions. I understand I can withdraw my consent at any time to information being shared and

Verbal consent obtained from the young person (subject to Gillick competence) Yes No

Verbal consent obtained from parent/carer Yes No

Comments (if any): Mum would appreciate support as she has been requesting support/interventions for the last several years

Date: