

Email: <Patient Contact Details>	<Relationships>
Looked After Child: <Read Code Check Box(image)>	Parental responsibility: <input type="checkbox"/> Yes <input type="checkbox"/> No
Disability: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, description of disability
<p>Is the Child subject to a Child Protection Plan: <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>CAF Referral <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>CAMHS Referral <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If child is attending CAMHS, at what stage is this?</p>	<p>Is GP aware of this referral?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p>TADS offer limited one to one therapy sessions and also small group workshops.</p> <p>Please indicate if group sessions may be a problem for this child/young person and if so why?</p>	

What has led you to make this referral?

(Please include details of child's mental health and how this is impacting on their daily life at home and at school)

i.e. school refusal, anxiety, social phobia, depression etc.

Any known medical conditions?

<Problems>

Child's view of this referral

Parent/Carers view of this referral

Are parents/carers committed to attending all appointments made by our service

Are there any barriers to attending any appointments

Signature of Referrer: Date: <Today's date>

I agree to this referral being made to TADS

Signature of Child: Date: <Today's date>

Signature of Parent/Carer: Date: <Today's date>

Parent or Carer must accompany child/young person to appointment